

3517

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 55 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY Jacksonville c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 48x-3 d. STREET ADDRESS 5746 Timuquana Road e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Richard Marshall ALLEN				4. DATE OF DEATH Month Day Year March 4 1960			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-18-23	
9. AGE (In years last birthday) 36		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles ALLEN				14. MOTHER'S MAIDEN NAME Bess WATERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW II			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 1 year			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 9 January , 19 60 , to 4 March , 19 60 , that I last saw the deceased alive on 4 March , 19 60 , and that death occurred at 6:35A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda Md. 3-7-60							
ACTUAL SIGNATURE <i>John Wood Waters</i>				M.D. U.S. Naval Hospital, Bethesda Md. 3-7-60			
PHYSICIAN'S NAME (Type) J.W. DAVIS LT MC USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-9-60		22c. NAME OF CEMETERY OR CREMATORY Tampa		22d. LOCATION (City, town, or county) (State) Tampa Florida	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers</i> ADDRESS W.W. Chambers 1400 Chapin St. N.W. Washington D.				24a. REC'D BY REGISTRAR DATE MAR 11 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

CERTIFICATE OF DEATH

Place

Jacksonville

25 days

Residence (Place)

U.S. Naval Hospital, Bethesda, Md.

2100 Wisconsin Road

Age

25 years

Residence

Sex

Male

Color

White

U.S.

U.S. Government

U.S. Government

U.S. Navy

Place of Birth

Place of Birth

U.S.

(Name) Oliver T. Allen

U.S. Navy

U.S. Navy

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

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U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

1
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3518

CERTIFICATE OF DEATH

03399

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Kennington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. STREET ADDRESS <u>3910 Baltimore St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rucille Drummond Appleby</u>				4. DATE OF DEATH Month Day Year <u>March 19 1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 18 1901</u>		9. AGE (In years lost birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Educ.</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Harry D. Appleby</u>				14. MOTHER'S MAIDEN NAME <u>Eleanor Bennet</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-36-7620</u>		INFORMANT <u>Charles Davidson</u> Address <u>3911 Baltimore St. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma, retroperitoneal, severe</u> 174 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Adenocarcinoma of uterus</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr +</u> <u>2 yrs +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral ureteral obstruction due to carcinoma, metastatic</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u></u> p. m. <u></u> 19 <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) <u></u> (County) <u></u> (State) <u></u>		21. I certify that I attended the deceased from <u>1957</u> , to <u>March 19, 1960</u> , that I last saw the deceased alive on <u>March 19, 1960</u> , and that death occurred at <u>8:10 PM</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stewart Clapp</u>		M.D. <u>3921 Ingomar St N.W.</u>		DATE SIGNED <u>3.19.60</u>			
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>		ADDRESS <u>Wash D.C.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/22/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>River View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Wilmington, Delaware</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. RECEIVED BY REGISTRAR <u>MAR 22 1960</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3519 CERTIFICATE OF DEATH

Reg. Dist. No.

64623

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Steve Middle (None) Last Archie		4. DATE OF DEATH Month March Day 28 Year 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 30, 1903
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months 7 Days hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY Milk Company	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Allen Archie		14. MOTHER'S MAIDEN NAME Pearl Marks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unascertainable	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive hemoptysis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of lung DUE TO (c) 7 months		INTERVAL BETWEEN ONSET AND DEATH 7 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 17, 1960 , to March 28, 1960 , that I last saw the deceased alive on March 28, 1960 , and that death occurred at 2:02A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard C. Mechanic		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3/28/60	
PHYSICIAN'S NAME (Type) RICHARD C. MECHANIC, M. D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) 3/28/60		22b. DATE THEREOF Ch. Cem.	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) Rock Hill, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arnold Luns Home ADDRESS 3116 Patrick St. City		24a. REC'D BY REGISTRAR 3/28/60 24b. REGISTRAR'S SIGNATURE Arthur S. Hays	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

VS A15 (4)
15M 9/58

1. Identification
2. Classification
3. Control
4. Dissemination
5. Retention
6. Disposition
7. Access
8. Security
9. Integrity
10. Availability
11. Confidentiality
12. Accuracy
13. Completeness
14. Timeliness
15. Consistency
16. Reliability
17. Verifiability
18. Accountability
19. Transparency
20. Openness
21. Participation
22. Collaboration
23. Cooperation
24. Coordination
25. Integration
26. Interoperability
27. Interfacing
28. Interchangeability
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1. Identification
2. Classification
3. Control
4. Dissemination
5. Retention
6. Disposition
7. Access
8. Security
9. Integrity
10. Availability
11. Confidentiality
12. Accuracy
13. Completeness
14. Timeliness
15. Consistency
16. Reliability
17. Verifiability
18. Accountability
19. Transparency
20. Openness
21. Participation
22. Collaboration
23. Cooperation
24. Coordination
25. Integration
26. Interoperability
27. Interfacing
28. Interchangeability
29. Interchangeability
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3456

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03400

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) o. STATE <u>md</u> b. COUNTY <u>P. S.</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> <u>1656.2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash-San. & Hosp</u>				d. STREET ADDRESS <u>1823 Kanawha St</u>			
3. NAME OF DECEASED (Type or print) <u>Carole June Astbury</u> First Middle Last				4. DATE OF DEATH Month <u>3</u> - Day <u>27</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-14-60</u>		9. AGE (In years last birthday) yrs. <u>2</u> Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min.	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Stewart Astbury</u>				14. MOTHER'S MAIDEN NAME <u>June Shupp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Stewart Astbury (father)</u>		Address <u>Stim 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>475X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Upper Respiratory Infection</u> DUE TO (c) <u>2 days</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brosch</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3-27-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>3-30-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred W. Kraiss</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 31 60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur A. Hanks</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Your files should be retained for burial, cremation, or removal.

2075374XV2

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>2 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Edward Alexander Bartlett</u>				4. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 19 1906</u>	9. AGE (In years last birthday) <u>53</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>28</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Education</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Administration</u>			
11. BIRTHPLACE (State or foreign country) <u>Northhamphshire</u>				12. CITIZEN OF WHAT COUNTRY? <u>US</u>			
13. FATHER'S NAME <u>Edward George BARTLETT</u>				14. MOTHER'S MAIDEN NAME <u>Laura Isabell Fredette</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1942-1946</u>				16. SOCIAL SECURITY NO. <u>0026-4450</u>			
17. INFORMANT <u>Marguerite Bartlett, same</u>				Address <u>024-7510</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis</u> (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>2-3 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3-15-60</u> to <u>3-15-60</u> , that I last saw the deceased alive on <u>3-15-60</u> , and that death occurred at <u>1050</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George A. Gray, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>4422 East West Hwy, Bethesda 14, Md.</u>			
PHYSICIAN'S NAME (Type) <u>George A. Gray, Jr.</u>				DATE SIGNED <u>3/15/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/19/60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>			
24a. RECEIVED BY REGISTRAR <u>MAR 18 60</u>				DATE			
24b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>							

CORONER NOTIFIED AND OK

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon portions. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3457
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

03402

1. PLACE OF DEATH o. COUNTY <u>Maryland</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>all</u> b. COUNTY <u>all</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>3 wks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash</u>		47X3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Green Rest Home</u> <u>7300 Baltimore Avenue</u>				d. STREET ADDRESS <u>6405-16 NW</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Laura Grace Bartlett</u> First Middle Last				4. DATE OF DEATH Month <u>3</u> Day <u>16</u> Year <u>1960</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov-23 1872</u>	9. AGE (In years lost birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Candy store</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James F. Bartlett</u>				14. MOTHER'S MAIDEN NAME <u>Ann C. Kitzel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mrs Ella E. Schulz</u> Address <u>6405-16 NW Washington</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Severe Arteriosclerosis (Hypertension)</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>1/17/1951</u> to <u>3/16/1960</u> , that (I) (we) last saw the deceased alive on <u>3/16/1960</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/16/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>T. Morse</u>				22d. ADDRESS <u>7030 Carroll Ave, Takoma Park Md</u>			
23a. BURIAL, CREMATION, REMOVAL, EXPOSURE <u>REMOVED</u>		23b. DATE THEREOF <u>3/19/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>		23d. LOCATION (City, town, or county) <u>Washington, D.C.</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>				25a. REC'D BY REGISTRAR <u>MAR 17 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

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CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS
BUREAU OF VITAL RECORDS

3431

1. Name of deceased: [illegible]

2. Sex: [illegible]

3. Age: [illegible]

4. Date of birth: [illegible]

5. Place of birth: [illegible]

6. Date of death: [illegible]

7. Place of death: [illegible]

8. Cause of death: [illegible]

9. Signature of physician: [illegible]

10. Signature of registrar: [illegible]

11. Signature of informant: [illegible]

12. Date of registration: [illegible]

13. Place of registration: [illegible]

14. Name of registrar: [illegible]

15. Name of informant: [illegible]

16. Name of physician: [illegible]

17. Name of hospital: [illegible]

18. Name of city: [illegible]

19. Name of state: [illegible]

20. Name of country: [illegible]

21. Name of district: [illegible]

22. Name of township: [illegible]

23. Name of county: [illegible]

24. Name of precinct: [illegible]

25. Name of ward: [illegible]

26. Name of block: [illegible]

27. Name of lot: [illegible]

28. Name of street: [illegible]

29. Name of avenue: [illegible]

30. Name of road: [illegible]

31. Name of bridge: [illegible]

32. Name of canal: [illegible]

33. Name of river: [illegible]

34. Name of lake: [illegible]

35. Name of bay: [illegible]

36. Name of harbor: [illegible]

37. Name of port: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03403

3458

Item 3, Film G-259 3/21/60 cac.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b <u>56</u> 5 <u>SILVER SPRING</u> <u>MD</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH. SAN. & Hosp</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1911 ELKART ST</u> d. STREET ADDRESS <u>1911 ELKART ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>VERNAL</u> Middle <u>MARIE</u> Last <u>Walston Bassett</u> 4. DATE OF DEATH Month <u>3</u> Day <u>6</u> Year <u>1960</u>				5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>1919</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>5-23-118</u> 9. AGE (In years last birthday) <u>40</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during 10 days prior to death) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Nat'l. Inst. Health</u> 11. BIRTHPLACE (State or foreign country) <u>Arkansas</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>JAMES WALSTON</u> 14. MOTHER'S MAIDEN NAME <u>PEARL ASHMORE</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>MR. Ralph S. Bassett</u> 17. INFORMANT <u>Stineas Dec</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>3-6-60</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>3/10/60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>MAR 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

3459

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

03404

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>57 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mrs. Ellen</u> Middle <u>Mary</u> Last <u>Becker</u>		4. DATE OF DEATH Month <u>March</u> Day <u>27</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 16, 1884</u>
9. AGE (In years lost birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States of America</u>	
13. FATHER'S NAME <u>Owen F. Gilmartin</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Loftus</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Hospital Records</u>		Address <u> </u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE, ACUTE</u> DUE TO <u>180X</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the <u>under-</u> lying cause last. (b) <u>RENAL CELL CARCINOMA WITH PULMONARY METASTASES</u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 1956</u> to <u>MARCH 27, 1960</u> . that (I) (we) last saw the deceased alive on <u>MARCH 27, 1960</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>Robert L. Krichmar</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>MARCH 27 1960</u>	22c. PHYSICIAN'S NAME (Type) <u>ROBERT L. KRICHMAR M.D.</u> 22d. ADDRESS <u>7733 ALASKA AVE N.W. WASH 12 D.C.</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>3/30/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Jones Co</u>		25a. REC'D BY REGISTRAR <u>2901-14</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Jones</u>
DATE <u>MAR 29 '60</u>			

63400

MINISTRY OF HEALTH
PUBLIC HEALTH SERVICE
CERTIFICATE OF DEATH

1952

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3506
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON	
c. LENGTH OF STAY IN 1b 4 yrs.		d. STREET ADDRESS 3717 Decatur Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3717 Decatur Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Grace Middle Harriet Last Beedle		4. DATE OF DEATH Month March Day 8 Year 19 60	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/31/78
9. AGE (In years last birthday) 81 88 yrs.		IF UNDER 1 YEAR Months 88 Days 88 Hours 88 Min.	IF UNDER 24 HRS. Hours 88 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) CONNECTICUT
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CLARENCE EDWIN BELL	
14. MOTHER'S MAIDEN NAME CARRIE WHITE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. Florence G. Mitchell, 3717 Decatur St. Kensington, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Tumor, right breast; Malignant?			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Feb 2 , 19 60 , to March 8 , 19 60 , that I last saw the deceased alive on March 5 , 19 60 , and that death occurred at 12:11 A.M., from the causes and on the date stated above.	
ACTUAL SIGNATURE Robert T. Thibadeau M.D.		ADDRESS (Street, city or town, state) 10609 Concord Street Kensington, Maryland	
DATE SIGNED March 8, 1960		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
22b. DATE THEREOF 3/11/60		22c. NAME OF CEMETERY OR CREMATORY Burtonsville Union Cemetery	
22d. LOCATION (City, town, or county) (State) Montgomery County, Md.		23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska	
ADDRESS SILVER SPRING, MD.		24a. REG'D BY REGISTRAR MAR 10 60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Place of birth: _____
6. Date of death: _____
7. Place of death: _____
8. Cause of death: _____
9. Signature of physician: _____
10. Signature of registrar: _____
11. Date of registration: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3460

CERTIFICATE OF DEATH

03406

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WASHINGTON D.C. b. COUNTY 47X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON D.C.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SANT + HOSPITAL		d. STREET ADDRESS 2440-16th ST NW.	
3. NAME OF DECEASED (Type or print) RANDOLPH H BELLMAN		4. DATE OF DEATH MARCH 9 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-26-92
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months	10. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY Robert Hall	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME OSCAR BELLMAN		14. MOTHER'S MAIDEN NAME VIRGINIA ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES (If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO. 577-07-5388	
17. INFORMANT MRS KATHERINE POLLOCK		Address 13116 ESTELLE RD S.S. MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH immediate
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from Dec 21, 1959 , to MARCH 9, 1960 , that I last saw the deceased alive on MARCH 3, 1960 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE Warner D. Brill M.D. M.D. _____			
PHYSICIAN'S NAME (Type) Warner D. Brill, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	3-14-1960	ARLINGTON NATH	FTMYER Va
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co ADDRESS 1400 Chapin ST NW, Wash D.C.		24a. REC'D BY REGISTRAR MAR 11 '60	24b. REGISTRAR'S SIGNATURE Warner D. Brill

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3436
CERTIFICATE OF DEATH

C3407

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1422 HIGHLAND DRIVE</u>				d. STREET ADDRESS <u>1422 HIGHLAND DRIVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>GODMAN</u> Last <u>BENGEL</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 17, 1896</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PATENT EXAMINER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOV'T.</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Wm. C. BENDEL</u>				14. MOTHER'S MAIDEN NAME <u>GODMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>W.W.I.</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>MRS BERNICE L. BENDEL</u>				Address <u>SILVER SPRING, MD. 1422 HIGHLAND DRIVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Essential hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>5 yrs</u> <u>25 yrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, locality, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb.</u> , 19 <u>50</u> , to <u>March 9</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>March 3</u> , 19 <u>60</u> , and that death occurred at <u>9:10 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Samuel M. Bageant</u>				ADDRESS (Street, city or town, state) <u>5600 N.H. Ave. Wash. D.C.</u> DATE SIGNED <u>3/9/60</u>			
PHYSICIAN'S NAME (Type) <u>SAMUEL M. BAGEANT, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Mar. 12, '60</u>		<u>FT. LINCOLN CEMETERY</u>		<u>Bladensburg Rd. Prince Georges Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kline</u>				ADDRESS <u>354 Carroll St. WASH. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 11 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

AGE

SEX

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DATE OF BIRTH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3521

CERTIFICATE OF DEATH

Reg. Dist. No.

03408

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 28 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 107 Dawson Avenue, Apt. # 117 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Nancy Lee Benton			4. DATE OF DEATH Month Day Year March 14 19 60				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1944	9. AGE (In years lost birthday) 16 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Maurice Benton				
14. MOTHER'S MAIDEN NAME Edna Millison			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				
16. SOCIAL SECURITY NO. None			17. ADDRESS The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Insufficiency 587.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Purulent tracheobronchitis DUE TO (c) Cystic Fibrosis of the Pancreas							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bethesda 14, Maryland			
21. I certify that I attended the deceased from February 15, 1960 , to March 14, 1960 , that I last saw the deceased alive on March 14, 1960 , and that death occurred at 9:25 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bethesda 14, Maryland DATE SIGNED 3/14/60							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 3/17/60		22c. NAME OF CEMETERY OR CREMATORY Conneaut Cemetery			
22d. LOCATION (City, town, or county) Conneaut, Ohio		23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland					
24a. REC'D BY REGISTRAR DATE MAR 16 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus					

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed, with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the hospital or attending physician.

by the hospital or attending physician.

OSPITAL

3507

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY COUNTY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>New Jersey</u> b. COUNTY <u>Paterson</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Paterson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>RoseLyn</u> First Middle Last		4. DATE OF DEATH Month <u>MARCH</u> Day <u>26</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 15 1894</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Pollock</u>		14. MOTHER'S MAIDEN NAME <u>Diana Hegner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>HWS BARD</u> (Isidor)	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Peritonitis</u> <u>155.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Biliary Carcinoma</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>3 Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/11</u> , 19 <u>60</u> to <u>3/26</u> , 19 <u>60</u> that I last saw the deceased alive on <u>3/26</u> , 19 <u>60</u> , and that death occurred at <u>6:50 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Max G. Stierer</u>		DATE SIGNED <u>3/26/60</u>	
PHYSICIAN'S NAME (Type) <u>Max G. STIERER MD</u>		ADDRESS (Street, city or town, state) <u>2025 East West A'way Silver Spring Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MARCH 27, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>KING DAVID MEMORIAL GARDEN</u>		22d. LOCATION (City, town, or county) (State) <u>FALLS CHURCH Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B Danyushy & Sons</u>		24a. REC'D BY REGISTRAR <u>MAR 29 '60</u>	
ADDRESS <u>3501-14 ST. N.W.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

page 3 should be detached for use by the funeral-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

03410

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Frank J. Broschart, Deputy Med. Examiner, notified and approved.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) ✓ a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, D.C.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>E. Hyattsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>1402 University Blvd. E.</u>			
3. NAME OF DECEASED (Type or print) <u>William Henry Black</u>				4. DATE OF DEATH <u>3 - 20 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>4-23-88</u>	9. AGE (In years lost birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office mgr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>? Black</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>579-01-9075-4</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive C.V. disease,</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>with annular fibulation</u> DUE TO <u>Atherosclerosis, advanced.</u> (c) <u>Adenocarcinoma prostate</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Many years.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 19 1960</u> to <u>Feb 19 1960</u> , that I last saw the deceased alive on <u>Feb 19 1960</u> , and that death occurred at <u>6:05 PM</u> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <u>1746 K Street N.W.</u> DATE SIGNED <u>Mar 2 2 '60</u>			
ACTUAL SIGNATURE <u>Irving Brotman</u>		M.D. <u>1746 K Street N.W.</u>					
PHYSICIAN'S NAME (Type) <u>IRVING BROTMAN, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MARCH 23 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u>		ADDRESS <u>8434 Ga. Ave. S-S. Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 2 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hesse</u>	

RECEIVED BY THE DIRECTOR, BUREAU OF THE CENSUS, WASHINGTON, D.C.

1910
CITY OF CHICAGO
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CHICAGO, ILL.
JANUARY 1, 1910
TO THE DIRECTOR, BUREAU OF THE CENSUS
WASHINGTON, D.C.
FROM THE CHIEF, BUREAU OF VITAL STATISTICS
CHICAGO, ILL.
SUBJECT: REPORT ON THE VITAL STATISTICS OF CHICAGO, ILL., FOR THE YEAR 1909.
The following report contains the vital statistics of Chicago, Ill., for the year 1909, as reported to the Bureau of Vital Statistics by the various local health departments.
The report is divided into two parts: the first part contains the general statistics, and the second part contains the detailed statistics by race, sex, age, and place of birth.
The general statistics show that the total population of Chicago, Ill., on January 1, 1910, was 2,896,742, an increase of 10.1% over the population of 2,628,000 reported in 1900.
The detailed statistics show that the total number of births in Chicago, Ill., for the year 1909, was 28,412, an increase of 1.1% over the number of 28,100 reported in 1908.
The total number of deaths in Chicago, Ill., for the year 1909, was 14,123, an increase of 1.1% over the number of 13,967 reported in 1908.
The report also shows that the total number of marriages in Chicago, Ill., for the year 1909, was 11,234, an increase of 1.1% over the number of 11,111 reported in 1908.
The report is submitted for the information of the Bureau of the Census, and is respectfully recommended for publication.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
note the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4
should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03411

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 TAKOMA PARK	
c. LENGTH OF STAY IN 1b 9 hrs.		d. STREET ADDRESS 8217 Roanoke Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SAN. & HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle JASON Last BLEVINS		4. DATE OF DEATH Month MAR. Day 23 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/18/58
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 1 Days 23 Hours 9 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HAROLD R. BLEVINS		14. MOTHER'S MAIDEN NAME GLADYS CLIFFORD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Harold R. Blevins, 8217 Roanoke Ave. Takoma Park, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOCK 917.0 DUE TO 2nd & 3rd degree burns involving about 1/3 of body Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 9 hrs. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pulled pan of boiling water from stove	
20c. TIME OF INJURY Month, Day, Year Hour 6 3-22-1960 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Takoma Park, Montgomery, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BROSCHART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 3/23/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL		22b. DATE THEREOF 3/24/60	
22c. NAME OF CEMETERY OR CREMATORY MARIANNA, ARKANSAS		22d. LOCATION (City, town, or county) (State) MARIANNA, ARKANSAS	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Jiska		24a. REC'D BY REGISTRAR DATE MAR 24 '60	
24b. REGISTRAR'S SIGNATURE John L. Hume			

MEDICAL CERTIFICATION

15

2

3522
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

03412

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS Watersville Road							
3. NAME OF DECEASED (Type or print) First Middle Last KATIE M. BLOOM				4. DATE OF DEATH Month Day Year March 30 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 28, 1904	
9. AGE (In years last birthday) yrs. 56		10. IF UNDER 1 YEAR Months Days Hours Min. 13X-2		11. IF UNDER 24 HRS. Months Days Hours Min. 13X-2			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Green				14. MOTHER'S MAIDEN NAME Emma Hatfield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -----				16. SOCIAL SECURITY NO. -----			
17. INFORMANT Calvin L. Bloom,				Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma - metastatic DUE TO Primary Adenocarcinoma Left Breast (Radical Breast Amputation Oct. 25, 1958) Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) 170X DUE TO (c) -----							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from August 1, 1949 to March 30, 1960 , that (I) (we) last saw the deceased alive on March 30, 1960 , and that death occurred at 1:15 a. m. , from the causes and on the date stated above.							
22a. SIGNATURE M. McKendree Boyer				22b. DATE SIGNED 3/30/60			
22c. PHYSICIAN'S NAME (Type) M. McKendree Boyer, M. D.				22d. ADDRESS 9830 Main Street Damascus, Maryland.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-2-1960		23c. NAME OF CEMETERY OR CREMATORY Poplar Springs Cemetery		23d. LOCATION (City, town, or county) (State) Howard Co. Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C.M. Waltz,				25a. REC'D BY REGISTRAR Winfield, Maryland			
25b. REGISTRAR'S SIGNATURE Arthur S. Hines				25c. REC'D BY REGISTRAR APR 4 '60			

CERTIFICATE OF DEATH

DECEASED

ONE I day

Montgomery E. General Hospital

WHITE

Female White

Housewife Domestic Maryland

George Eason

Calvin L. Dixon

Public Coroner Cemetery Howard Co. Maryland

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03413

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ivory Middle Dennis Last Bowen		4. DATE OF DEATH Month March Day 8 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3, 1953
9. AGE (In years last birthday) 6 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Child	
11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Paul H. Bowen		14. MOTHER'S MAIDEN NAME Betty Jo Wells	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Father - Paul H. Bowen		Address -----	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 921.0 Suffocation DUE TO Foreign body in larynx (chewing gum) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ----- DUE TO (c) -----		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Tracheobronchitis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. Aspirated chewing gum while coughing		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year March 8, 1960 Hour 9 a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		20f. (City or town) Kensington (County) Montgomery (State) MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-14-60	
22c. NAME OF CEMETERY OR CREMATORY Gate City		22d. LOCATION (City, town, or county) Gate City (State) Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE N. Don. DeVol		ADDRESS 2224 Wisconsin Ave. N.E.	
24a. REC'D BY REGISTRAR -----		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	
DATE MAR 14 '60		DATE -----	

3-9-60

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEATH OF DECEASED COUNTY		DECEASED BY	
A CITY OR TOWNSHIP OF THE STATE OF MARYLAND		IN THE COUNTY OF	
DECEASED		DECEASED	
3208 Madison Ave. BALTIMORE, MD.		DECEASED HOSPITAL	
SEX		SEX	
MALE		MALE	
DATE OF BIRTH		DATE OF BIRTH	
1900		1900	
AGE		AGE	
30		30	
OCCUPATION		OCCUPATION	
LABORER		LABORER	
CAUSE OF DEATH		CAUSE OF DEATH	
HEART DISEASE		HEART DISEASE	
MANNER OF DEATH		MANNER OF DEATH	
NATURAL		NATURAL	
SIGNATURE OF EXAMINER		SIGNATURE OF EXAMINER	
JAMES H. HARRIS		JAMES H. HARRIS	
DATE OF EXAMINATION		DATE OF EXAMINATION	
1930		1930	
PLACE OF EXAMINATION		PLACE OF EXAMINATION	
BALTIMORE, MD.		BALTIMORE, MD.	
TIME OF EXAMINATION		TIME OF EXAMINATION	
10:00 AM		10:00 AM	
SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES H. HARRIS		JAMES H. HARRIS	
DATE OF EXAMINATION		DATE OF EXAMINATION	
1930		1930	
PLACE OF EXAMINATION		PLACE OF EXAMINATION	
BALTIMORE, MD.		BALTIMORE, MD.	
TIME OF EXAMINATION		TIME OF EXAMINATION	
10:00 AM		10:00 AM	

3524

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b X Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. STREET ADDRESS 4608 Highland Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bessie Middle G. Last Britton				4. DATE OF DEATH Month 3 Day 2 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/18/02	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months 57 Days 57 Hours 57 Min.	IF UNDER 24 HRS. Months 57 Days 57 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) WASH D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME STUART GARBER				14. MOTHER'S MAIDEN NAME SALLY MAUCK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		INFORMANT Address HUSBAND - SAME as Above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X Congestive Heart Failure DUE TO (b) Metastatic Carcinoma Lungs, Liver, Spine DUE TO (c) Carcinoma Right Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 1 MONTH 5 YRS 10 1/2 YRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAR 16 , 19 53 , to MAR 4 , 19 60 , that I last saw the deceased alive on MAR 4 , 19 60 , and that death occurred at 2:05 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert G. Angle		ADDRESS (Street, city or town, state) DATE SIGNED 5009 DelRay Ave Bethesda, Md 3/4/60					
PHYSICIAN'S NAME (Type) Robert G. Angle		5009 DelRay Ave. Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/8/60		22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR MAR 11 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

2. be retained by the hospital or attending physician.

3. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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2

CERTIFICATE OF DEATH

3252

[Faint, mostly illegible text on a form with multiple lines and sections. The text appears to be a record of a death, possibly from the early 20th century. Some legible fragments include:]

[Line 1: Name of deceased]

[Line 2: Date of death]

[Line 3: Place of death]

[Line 4: Cause of death]

[Line 5: Signature of physician]

[Line 6: Signature of registrar]

[Line 7: Date of registration]

[Line 8: Place of registration]

[Line 9: Name of registrar]

[Line 10: Name of physician]

[Line 11: Name of informant]

[Line 12: Name of informant]

[Line 13: Name of informant]

[Line 14: Name of informant]

[Line 15: Name of informant]

[Line 16: Name of informant]

[Line 17: Name of informant]

[Line 18: Name of informant]

[Line 19: Name of informant]

[Line 20: Name of informant]

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3512

CERTIFICATE OF DEATH

Reg. Dist. No.

03416

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. LENGTH OF STAY IN 1b 26 Rockville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 101 N. Adams Street				d. STREET ADDRESS 101 N. Adams Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH ENGLAND BROWN				4. DATE OF DEATH Month Day Year March 26, 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1875		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Trew England				14. MOTHER'S MAIDEN NAME Annie Griffith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Address W. Maynard Brown 48 Colonial Ridge Dr. Haddonfield, N. J.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 1 wk 20 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 25, 1952 to 26 March 1960 that I last saw the deceased alive on 26 March 1960 , and that death occurred at 5:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3/26/60 DATE SIGNED ACTUAL SIGNATURE W.S. Murphy M.D. PHYSICIAN'S NAME (Type) W.S. Murphy 615 W. Montgomery Ave., Rockville, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-28-60		22c. NAME OF CEMETERY OR CREMATORY Chester		22d. LOCATION (City, town, or county) (State) Chestertown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Tyson Wheeler- 1331 E. Montg. Ave. Rockville, Md.				24a. REC'D BY REGISTRAR DATE MAR 30 '60		24b. REGISTRAR'S SIGNATURE Arthur S. H... ..	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03417

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park D.C.</u> c. LENGTH OF STAY IN 1b <u>D.C.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Howard</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u> 13X-2 d. STREET ADDRESS <u>404 Montrose Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Wilmer Martin Burch</u> First Middle Last		4. DATE OF DEATH Month <u>3</u> Day <u>27</u> Year <u>1960</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. B. DATE OF BIRTH <u>9-30-03</u> 9. AGE (In years last birthday) <u>56</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SERVICE - U.S. ARMY</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>ARMED FORCES</u> 11. BIRTHPLACE (State or foreign country) <u>Waldorf Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>					
13. FATHER'S NAME <u>JESSIE BURCH</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>W.W. II - KOREAN</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET</u> 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Virginia M. Burch</u> Address <u>939 Bonifant St. S.S.Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LACERATION AND RUPTURE OF HEART DUE TO CRUSHED</u> <u>816X</u> DUE TO <u>CHEST</u> minutes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>816X</u> DUE TO <u>CHEST</u> (c)				INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>816X</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of car involved in 2 car accident - struck by 3rd car</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>2</u> p.m. <u>3-27</u> 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Ad. R-2900 Col. Rd.</u> 20f. (City or town) <u>Howard</u> (County) <u>MD</u> (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Blossch</u> M.D. EXAMINER'S NAME (Type) <u>FRANK J. BLOSSCH M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3-27-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 30, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u> ADDRESS <u>254 Carroll St. N.W.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> DATE <u>MAR 30 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			
22d. LOCATION (City, town, or county) <u>Virginia</u> (State)							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

3526
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03418

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Frederick, Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 30 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ijamsville d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ralph Middle Mc Sherry Last Burgee		4. DATE OF DEATH Month March Day 5 Year 19 60	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/21/03
9. AGE (In years lost birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Public School	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mc Sherry Burgee		14. MOTHER'S MAIDEN NAME Nettie Day	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-22-7627	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio-Vascular-Renal Disease 442X DUE TO ① Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO ② Renal Infarct and embolism (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ① Diabetes Mellitus ② Parkinson's Disease			INTERVAL BETWEEN ONSET AND DEATH 10 years 5 years 3 weeks
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1960 to March 5, 1960 , that (I) (we) last saw the deceased alive on March 5, 1960 , and that death occurred at 10:29 M, from the causes and on the date stated above.			
22a. SIGNATURE M. McKendree Boyer		22b. DATE SIGNED 3/6/60	
22c. PHYSICIAN'S NAME (Type) M. McKendree Boyer		22d. ADDRESS 9830 Main St. Ijamsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-8-60	
23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Frederick, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. L. Burdette, Hyattstown, Maryland		25a. REC'D BY REGISTRAR DATE MAR 10 '60	
		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

1918

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

3522

DATE OF DEATH

1918

DECEASED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03419

3527

Item 4, Film G-259 5/21/60, etc.

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 57			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5015 Del Ray Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nell Middle F Last Butler				4. DATE OF DEATH Month March Day 13 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/6/1882	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 5 Days 7		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) England	
12. CITIZEN OF WHAT COUNTRY? U S							
13. FATHER'S NAME Charles Forsdick				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Cunningham-daughter-same as 2d	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction 420.0 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anterior inferior heart disease (c) 				INTERVAL BETWEEN ONSET AND DEATH 1/2 day 1/2 day 2+yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	
20f. (City or town) 				20g. (County) 		20h. (State) 	
21. I certify that (I) (this hospital) attended the deceased from July 1959 to Mar. 12 1960 that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 19 , and that death occurred at M, from the causes and on the date stated above.							
22a. SIGNATURE W. H. Richwine				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12 Mar. 60	
22c. PHYSICIAN'S NAME (Type) W. H. RICHWINE, M.D.				22d. ADDRESS 5322 WESTERN AVE CHEVY CHASE, D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/15/60		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Prince George Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR MAR 16 '60	
						25b. REGISTRAR'S SIGNATURE Arthur L. Frank	

2. 22.11.1992 1994

3523

CERTIFICATE OF DEATH

Reg. Dist. No.

03420

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE _____ b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5521 Grosvenor Lane Resmor Sanit.</u>				d. STREET ADDRESS <u>2725 29th St NW</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mabel Frank Butterfield</u>				4. DATE OF DEATH Month Day Year <u>3 5 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-27-1870</u>	
9. AGE (In years last birthday) yrs. <u>89</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Illinois</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>	
13. FATHER'S NAME <u>THOMPSON</u>				14. MOTHER'S MAIDEN NAME <u>Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S NAME AND ADDRESS <u>Mrs. Willa Westcott</u> <u>2725-29th St NW Washington, DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>? Bronchopneumonia</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of femur, recent</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> , to <u>5 Mar, 1960</u> , that I last saw the deceased alive on <u>29 Feb</u> , 19 <u>60</u> , and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Robert T. Kelley</u> M.D. <u>3132-16 St. NW, DC.</u> PHYSICIAN'S NAME (Type) <u>Robert T. Kelley</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				22b. DATE THEREOF <u>3/6/1960</u>		22c. NAME OF CEMETERY OR CREMATORY	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u> ADDRESS <u>2901-14th St NW-DC</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Farns</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911-1912

<p>1. NAME OF DECEASED [Name of deceased]</p>		<p>2. SEX [Male/Female]</p>	
<p>3. AGE [Age of deceased]</p>		<p>4. DATE OF DEATH [Date of death]</p>	
<p>5. PLACE OF DEATH [Place of death]</p>		<p>6. CAUSE OF DEATH [Cause of death]</p>	
<p>7. OCCUPATION [Occupation]</p>		<p>8. MARITAL STATUS [Married/Single]</p>	
<p>9. PLACE OF BIRTH [Place of birth]</p>		<p>10. DATE OF BIRTH [Date of birth]</p>	
<p>11. NAME OF PHYSICIAN [Name of physician]</p>		<p>12. NAME OF CORONER [Name of coroner]</p>	
<p>13. NAME OF FUNERAL HOME [Name of funeral home]</p>		<p>14. NAME OF BURIAL PLACE [Name of burial place]</p>	
<p>15. NAME OF WITNESS [Name of witness]</p>		<p>16. NAME OF WITNESS [Name of witness]</p>	
<p>17. NAME OF WITNESS [Name of witness]</p>		<p>18. NAME OF WITNESS [Name of witness]</p>	
<p>19. NAME OF WITNESS [Name of witness]</p>		<p>20. NAME OF WITNESS [Name of witness]</p>	
<p>21. NAME OF WITNESS [Name of witness]</p>		<p>22. NAME OF WITNESS [Name of witness]</p>	
<p>23. NAME OF WITNESS [Name of witness]</p>		<p>24. NAME OF WITNESS [Name of witness]</p>	
<p>25. NAME OF WITNESS [Name of witness]</p>		<p>26. NAME OF WITNESS [Name of witness]</p>	
<p>27. NAME OF WITNESS [Name of witness]</p>		<p>28. NAME OF WITNESS [Name of witness]</p>	
<p>29. NAME OF WITNESS [Name of witness]</p>		<p>30. NAME OF WITNESS [Name of witness]</p>	
<p>31. NAME OF WITNESS [Name of witness]</p>		<p>32. NAME OF WITNESS [Name of witness]</p>	
<p>33. NAME OF WITNESS [Name of witness]</p>		<p>34. NAME OF WITNESS [Name of witness]</p>	
<p>35. NAME OF WITNESS [Name of witness]</p>		<p>36. NAME OF WITNESS [Name of witness]</p>	
<p>37. NAME OF WITNESS [Name of witness]</p>		<p>38. NAME OF WITNESS [Name of witness]</p>	
<p>39. NAME OF WITNESS [Name of witness]</p>		<p>40. NAME OF WITNESS [Name of witness]</p>	
<p>41. NAME OF WITNESS [Name of witness]</p>		<p>42. NAME OF WITNESS [Name of witness]</p>	
<p>43. NAME OF WITNESS [Name of witness]</p>		<p>44. NAME OF WITNESS [Name of witness]</p>	
<p>45. NAME OF WITNESS [Name of witness]</p>		<p>46. NAME OF WITNESS [Name of witness]</p>	
<p>47. NAME OF WITNESS [Name of witness]</p>		<p>48. NAME OF WITNESS [Name of witness]</p>	
<p>49. NAME OF WITNESS [Name of witness]</p>		<p>50. NAME OF WITNESS [Name of witness]</p>	
<p>51. NAME OF WITNESS [Name of witness]</p>		<p>52. NAME OF WITNESS [Name of witness]</p>	
<p>53. NAME OF WITNESS [Name of witness]</p>		<p>54. NAME OF WITNESS [Name of witness]</p>	
<p>55. NAME OF WITNESS [Name of witness]</p>		<p>56. NAME OF WITNESS [Name of witness]</p>	
<p>57. NAME OF WITNESS [Name of witness]</p>		<p>58. NAME OF WITNESS [Name of witness]</p>	
<p>59. NAME OF WITNESS [Name of witness]</p>		<p>60. NAME OF WITNESS [Name of witness]</p>	
<p>61. NAME OF WITNESS [Name of witness]</p>		<p>62. NAME OF WITNESS [Name of witness]</p>	
<p>63. NAME OF WITNESS [Name of witness]</p>		<p>64. NAME OF WITNESS [Name of witness]</p>	
<p>65. NAME OF WITNESS [Name of witness]</p>		<p>66. NAME OF WITNESS [Name of witness]</p>	
<p>67. NAME OF WITNESS [Name of witness]</p>		<p>68. NAME OF WITNESS [Name of witness]</p>	
<p>69. NAME OF WITNESS [Name of witness]</p>		<p>70. NAME OF WITNESS [Name of witness]</p>	
<p>71. NAME OF WITNESS [Name of witness]</p>		<p>72. NAME OF WITNESS [Name of witness]</p>	
<p>73. NAME OF WITNESS [Name of witness]</p>		<p>74. NAME OF WITNESS [Name of witness]</p>	
<p>75. NAME OF WITNESS [Name of witness]</p>		<p>76. NAME OF WITNESS [Name of witness]</p>	
<p>77. NAME OF WITNESS [Name of witness]</p>		<p>78. NAME OF WITNESS [Name of witness]</p>	
<p>79. NAME OF WITNESS [Name of witness]</p>		<p>80. NAME OF WITNESS [Name of witness]</p>	
<p>81. NAME OF WITNESS [Name of witness]</p>		<p>82. NAME OF WITNESS [Name of witness]</p>	
<p>83. NAME OF WITNESS [Name of witness]</p>		<p>84. NAME OF WITNESS [Name of witness]</p>	
<p>85. NAME OF WITNESS [Name of witness]</p>		<p>86. NAME OF WITNESS [Name of witness]</p>	
<p>87. NAME OF WITNESS [Name of witness]</p>		<p>88. NAME OF WITNESS [Name of witness]</p>	
<p>89. NAME OF WITNESS [Name of witness]</p>		<p>90. NAME OF WITNESS [Name of witness]</p>	
<p>91. NAME OF WITNESS [Name of witness]</p>		<p>92. NAME OF WITNESS [Name of witness]</p>	
<p>93. NAME OF WITNESS [Name of witness]</p>		<p>94. NAME OF WITNESS [Name of witness]</p>	
<p>95. NAME OF WITNESS [Name of witness]</p>		<p>96. NAME OF WITNESS [Name of witness]</p>	
<p>97. NAME OF WITNESS [Name of witness]</p>		<p>98. NAME OF WITNESS [Name of witness]</p>	
<p>99. NAME OF WITNESS [Name of witness]</p>		<p>100. NAME OF WITNESS [Name of witness]</p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3529

Reg. Dist. No.

03421

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kennedy & Dean Rds</u>			d. STREET ADDRESS <u>5244 44th St N.W</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Warren Franklin Byrd</u>			4. DATE OF DEATH Month Day Year <u>March 3 1960</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-24-91</u>		9. AGE (In years last birthday) <u>68</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>may chief-CPO retired</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		11. BIRTHPLACE (State or foreign country) <u>41. S. C.</u>
13. FATHER'S NAME <u>Wm Byrd</u>			14. MOTHER'S MAIDEN NAME <u>Sally Sterling</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>578-30-5198</u>		17. INFORMANT <u>Robt Byrd (son)</u> Address <u>2009 N. Semine St Arlington, Va</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary edema</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial insufficiency</u> DUE TO (c) <u>Coronary insufficiency</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Healed myocardial infarction</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3-4-60</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 3-5-60</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Asbury Methodist Church Cem., Crisfield, Maryland.</u>	
22d. LOCATION (City, town, or county) (State)		23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY, Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 7 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

3530

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 68 Hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle M Last Byrne		4. DATE OF DEATH Month March Day 7 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/6/14
9. AGE (In years lost birthday) 45 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ----	
11. BIRTHPLACE (State or foreign country) Berryville, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thadeus Montague Whiting		14. MOTHER'S MAIDEN NAME Lelila Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Wac Army Unknown	
17. INFORMANT Husband John J. Byrne (Same as above)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X Atherosclerosis, Reticulo-endothelial DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 6 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 5, 1952 to March 7, 1960 , that I last saw the deceased alive on March 7, 1960 , and that death occurred at 7:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE P. P. Tabb		ADDRESS (Street, city or town, state) 1300 Georgia Ave. Silver Spring	
PHYSICIAN'S NAME (Type) Samuel Tabb		DATE SIGNED 3/7/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/11/60	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		24a. REC'D BY REGISTRAR Bethesda, Maryland	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume		DATE MAR 10 '60	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3531

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE West Virginia b. COUNTY West Virginia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 67 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clayton Middle Jay Last Byus				4. DATE OF DEATH Month March Day 15 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 5, 1950	
9. AGE (In years last birthday) 9 yrs.		IF UNDER 1 YEAR Months 9 Days 15 Hours 15 Min.		IF UNDER 24 HRS. Months 9 Days 15 Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Jerry Robert Byus				14. MOTHER'S MAIDEN NAME Mary E. Jacobs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
INFORMANT Address The Medical Record The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive G. I. hemorrhage 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute lymphocytic leukemia DUE TO (c) 1 year PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from January 8, 19 60 to March 15, 19 60 that I last saw the deceased alive on March 15, 19 60 , and that death occurred at 5:50A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center Bethesda 14, Maryland DATE SIGNED 3/15/60							
ACTUAL SIGNATURE Arthur R. Rothman M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland							
PHYSICIAN'S NAME (Type) ARTHUR R. ROTHMAN, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) SHIP RR. 3-16-1960							
22b. DATE THEREOF 3-16-1960							
22c. NAME OF CEMETERY OR CREMATORY Point Pleasant West Va							
22d. LOCATION (City, town, or county) (State)							
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co 1400 Chapin St NW ADDRESS Wash DC							
24a. REC'D BY REGISTRAR DATE MAR 17 '60							
24b. REGISTRAR'S SIGNATURE Carlton S. Kline							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Between
the clinical center, Bethesda, Md.
and
the clinical center, Bethesda, Md.
on
June 2, 1950

West Virginia
State
No. 10
Name
Age
Sex
Race
Occupation
Cause of Death
Date of Death
Place of Death
Signature of Physician
Signature of Registrar

January 8, 1950
The Clinical Center
National Institutes of Health
Bethesda, Md., Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3464 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03424

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>D. C.</u> b. COUNTY <u>Washington D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>DOA.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>		47X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium Hosp.</u>				d. STREET ADDRESS <u>7421 Blair Rd NW</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Paul Herbert Camp.</u>				4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-10-95</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during preceding year if required) <u>LABORATORY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FISHER SCIENTIFIC LAB.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hubert Camp.</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Dixon Dixon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>WW 1</u>		17. INFORMANT Address <u>Mrs Elizabeth C. Camp.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		3-1-60	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	22b. DATE THEREOF <u>3/3/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>WARNER E. PUMPHREY, INC. SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 3 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William L. Thompson</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED LAST, FIRST, MIDDLE (Print or type name in full)		SEX Male <input type="checkbox"/> Female <input type="checkbox"/>	
AGE Years _____ Months _____ Days _____		RACE White <input type="checkbox"/> Negro <input type="checkbox"/> Other _____	
DATE OF DEATH Month _____ Day _____ Year _____		TIME OF DEATH Hour _____ Minute _____	
PLACE OF DEATH City _____ State _____		HOME ADDRESS Street _____ City _____ State _____	
OCCUPATION _____		CAUSE OF DEATH (List in order of sequence)	
MANNER OF DEATH Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Undetermined <input type="checkbox"/>		MEDICAL HISTORY (List all diseases, injuries, operations, etc., in order of sequence)	
PRESENT ILLNESS (List all symptoms, signs, and treatments in order of sequence)		POST-MORTEM EXAMINATION (List all findings in order of sequence)	
SIGNATURE OF EXAMINER _____		SIGNATURE OF WITNESS _____	
DATE OF SIGNATURE _____		DATE OF SIGNATURE _____	

3532

CERTIFICATE OF DEATH

Reg. Dist. No.

03425

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	c. LENGTH OF STAY IN 1b <u>4 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boysds</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Emma Rebecca</u> First Middle Last <u>Carlin</u>		4. DATE OF DEATH Month <u>3</u> Day <u>16</u> Year <u>60</u> 19	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 22 1898</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nat</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Boysds Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Wm Edgar Larmen</u>	
14. MOTHER'S MAIDEN NAME <u>Catherine Rebecca Thompson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>MISS FRANCES R. CARLIN</u>		INFORMANT Address <u>2800 Quebec St Wash. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Atypical</u> 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Pulmonary Fibrosis + Emphysema</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chr Pulmonale</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>8 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 20, 1951</u> , to <u>March 16, 1960</u> , that I last saw the deceased alive on <u>15 March 1960</u> , and that death occurred at <u>8:55 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Gordon M. Smith</u> M.D.		ADDRESS (Street, city or town, state) <u>Barnesville, Md.</u> DATE SIGNED <u>16 March 60</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>3/19/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>	22d. LOCATION (City, town, or county) (State) <u>Barnesville Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hillen</u> ADDRESS <u>Barnesville, Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 21 1960</u>	24b. REGISTRAR'S SIGNATURE <u>William B. Hillen</u>

1

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

STATE OF NEW YORK
CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

GRANDCHILDREN

ESTATE

DECEASED'S SIGNATURE

WITNESSES

MINISTER OF THE GOSPEL

CLERGYMAN

NOTARY PUBLIC

DECEASED'S SIGNATURE

WITNESSES

MINISTER OF THE GOSPEL

CLERGYMAN

NOTARY PUBLIC

DECEASED'S SIGNATURE

WITNESSES

MINISTER OF THE GOSPEL

CLERGYMAN

NOTARY PUBLIC

DECEASED'S SIGNATURE

WITNESSES

MINISTER OF THE GOSPEL

CLERGYMAN

NOTARY PUBLIC

DECEASED'S SIGNATURE

WITNESSES

MINISTER OF THE GOSPEL

CLERGYMAN

NOTARY PUBLIC

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, Film G258, 3/16/60 1 CERTIFICATE OF DEATH

Reg. Dist. No.

03426

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1 Bethesda, MD</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>M</u> Last <u>Carter</u>		4. DATE OF DEATH Month <u>3</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 11 1877</u>
9. AGE (In years last birthday) <u>83 1/2</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.F.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HARDEN CARTER</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE V. FLEENOR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>026-0950</u>	
17. INFORMANT <u>SON) WALTER H CARTER</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>coronary atherosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>acute congestive heart failure</u> INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>59</u> , to <u>March 4, 1960</u> , that I last saw the deceased alive on <u>Feb 29</u> , 19 <u>60</u> , and that death occurred at <u>1:30</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilfred R. Ehrmantraut M.D.</u>		ADDRESS (Street, city or town, state) <u>4890 Beechery Lane, Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmantraut M.D.</u>		DATE SIGNED <u>3/4/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/7/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>East Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Geiers Sons Co</u>		ADDRESS <u>3605-14 St NW Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>DATE MAR 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

MAINTAINED IN THE DEPARTMENT OF HEALTH

1914

3503

NAME OF DECEASED

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

PERIOD OF ILLNESS

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ACCIDENTS

PREVIOUS MENTAL ILLNESS

PREVIOUS PHYSICAL ILLNESS

PREVIOUS SOCIAL HISTORY

PREVIOUS FAMILY HISTORY

PREVIOUS PERSONAL HISTORY

PREVIOUS MEDICAL HISTORY

PREVIOUS SURGICAL HISTORY

PREVIOUS TRAUMATIC HISTORY

PREVIOUS DRUG HISTORY

PREVIOUS ACCIDENT HISTORY

PREVIOUS MENTAL HISTORY

PREVIOUS PHYSICAL HISTORY

PREVIOUS SOCIAL HISTORY

PREVIOUS FAMILY HISTORY

PREVIOUS PERSONAL HISTORY

PREVIOUS MEDICAL HISTORY

PREVIOUS SURGICAL HISTORY

PREVIOUS TRAUMATIC HISTORY

PREVIOUS DRUG HISTORY

PREVIOUS ACCIDENT HISTORY

PREVIOUS MENTAL HISTORY

PREVIOUS PHYSICAL HISTORY

PREVIOUS SOCIAL HISTORY

PREVIOUS FAMILY HISTORY

PREVIOUS PERSONAL HISTORY

PREVIOUS MEDICAL HISTORY

PREVIOUS SURGICAL HISTORY

PREVIOUS TRAUMATIC HISTORY

PREVIOUS DRUG HISTORY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03427

3534

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>57 Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>			d. STREET ADDRESS <u>9412 Locust Hill Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>Horace</u> Last <u>Chadwick</u>			4. DATE OF DEATH Month <u>3</u> Day <u>16</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 18, 1888</u>		9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR Months <u>4</u> Days <u>28</u> IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Horace Chadwick</u>		
14. MOTHER'S MAIDEN NAME <u>Anna E. Edwards</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>yes-Unknown</u>			17. INFORMANT <u>Marie E. Chadwick - same - wife</u> Address <u>2d</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>4201</u> (a), stating the underlying cause last. (c) <u>DUE TO</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>3/17/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	
22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunt</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> <u>Bethesda, Maryland</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male	
3. AGE 45		4. RACE White	
5. DATE OF DEATH April 15, 1945		6. TIME OF DEATH 10:30 AM	
7. PLACE OF DEATH Home		8. CAUSE OF DEATH Heart Disease	
9. MANNER OF DEATH Natural		10. SIGNATURE OF EXAMINER J. H. HARRIS	
11. SIGNATURE OF WITNESSES J. H. HARRIS		12. SIGNATURE OF CORONER J. H. HARRIS	
13. SIGNATURE OF PHYSICIAN J. H. HARRIS		14. SIGNATURE OF JURY J. H. HARRIS	
15. SIGNATURE OF DECEASED J. H. HARRIS		16. SIGNATURE OF NEXT OF KIN J. H. HARRIS	
17. SIGNATURE OF BURIAL SOCIETY J. H. HARRIS		18. SIGNATURE OF FUNERAL HOME J. H. HARRIS	
19. SIGNATURE OF CEMETERY J. H. HARRIS		20. SIGNATURE OF INTERVIEWER J. H. HARRIS	
21. SIGNATURE OF REPORTER J. H. HARRIS		22. SIGNATURE OF CLERK J. H. HARRIS	
23. SIGNATURE OF RECEPTIONIST J. H. HARRIS		24. SIGNATURE OF TELEPHONE OPERATOR J. H. HARRIS	
25. SIGNATURE OF MAIL ROOM J. H. HARRIS		26. SIGNATURE OF RECORDS SECTION J. H. HARRIS	
27. SIGNATURE OF IDENTIFICATION SECTION J. H. HARRIS		28. SIGNATURE OF LABORATORY J. H. HARRIS	
29. SIGNATURE OF RADIOLOGY J. H. HARRIS		30. SIGNATURE OF PATHOLOGY J. H. HARRIS	
31. SIGNATURE OF ANATOMY J. H. HARRIS		32. SIGNATURE OF PHYSIOLOGY J. H. HARRIS	
33. SIGNATURE OF PSYCHOLOGY J. H. HARRIS		34. SIGNATURE OF SOCIOLOGY J. H. HARRIS	
35. SIGNATURE OF POLITICAL SCIENCE J. H. HARRIS		36. SIGNATURE OF ECONOMICS J. H. HARRIS	
37. SIGNATURE OF HISTORY J. H. HARRIS		38. SIGNATURE OF GEOGRAPHY J. H. HARRIS	
39. SIGNATURE OF MATHEMATICS J. H. HARRIS		40. SIGNATURE OF SCIENCE J. H. HARRIS	
41. SIGNATURE OF ARTS J. H. HARRIS		42. SIGNATURE OF LETTERS J. H. HARRIS	
43. SIGNATURE OF LAW J. H. HARRIS		44. SIGNATURE OF MEDICINE J. H. HARRIS	
45. SIGNATURE OF DENTISTRY J. H. HARRIS		46. SIGNATURE OF VETERINARY MEDICINE J. H. HARRIS	
47. SIGNATURE OF AGRICULTURE J. H. HARRIS		48. SIGNATURE OF FISHERIES J. H. HARRIS	
49. SIGNATURE OF MINING J. H. HARRIS		50. SIGNATURE OF METALLURGY J. H. HARRIS	
51. SIGNATURE OF CHEMISTRY J. H. HARRIS		52. SIGNATURE OF PHYSICS J. H. HARRIS	
53. SIGNATURE OF BIOLOGY J. H. HARRIS		54. SIGNATURE OF BOTANY J. H. HARRIS	
55. SIGNATURE OF ZOOLOGY J. H. HARRIS		56. SIGNATURE OF ASTRONOMY J. H. HARRIS	
57. SIGNATURE OF COSMOLOGY J. H. HARRIS		58. SIGNATURE OF METEOROLOGY J. H. HARRIS	
59. SIGNATURE OF CLIMATE J. H. HARRIS		60. SIGNATURE OF SOIL SCIENCE J. H. HARRIS	
61. SIGNATURE OF AGRICULTURAL MECHANICS J. H. HARRIS		62. SIGNATURE OF INDUSTRIAL MECHANICS J. H. HARRIS	
63. SIGNATURE OF AUTOMOBILE MECHANICS J. H. HARRIS		64. SIGNATURE OF AIRCRAFT MECHANICS J. H. HARRIS	
65. SIGNATURE OF MARINE ENGINEERING J. H. HARRIS		66. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS	
67. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS		68. SIGNATURE OF CIVIL ENGINEERING J. H. HARRIS	
69. SIGNATURE OF ARCHITECTURE J. H. HARRIS		70. SIGNATURE OF LAND SURVEYING J. H. HARRIS	
71. SIGNATURE OF CONSTRUCTION J. H. HARRIS		72. SIGNATURE OF MINING ENGINEERING J. H. HARRIS	
73. SIGNATURE OF METALLURGICAL ENGINEERING J. H. HARRIS		74. SIGNATURE OF CHEMICAL ENGINEERING J. H. HARRIS	
75. SIGNATURE OF INDUSTRIAL ENGINEERING J. H. HARRIS		76. SIGNATURE OF AERONAUTICAL ENGINEERING J. H. HARRIS	
77. SIGNATURE OF AEROSPACE ENGINEERING J. H. HARRIS		78. SIGNATURE OF NAUTICAL ENGINEERING J. H. HARRIS	
79. SIGNATURE OF MARINE ENGINEERING J. H. HARRIS		80. SIGNATURE OF COASTAL ENGINEERING J. H. HARRIS	
81. SIGNATURE OF PORT ENGINEERING J. H. HARRIS		82. SIGNATURE OF WATERWAY ENGINEERING J. H. HARRIS	
83. SIGNATURE OF IRRIGATION ENGINEERING J. H. HARRIS		84. SIGNATURE OF HYDRAULIC ENGINEERING J. H. HARRIS	
85. SIGNATURE OF SANITARY ENGINEERING J. H. HARRIS		86. SIGNATURE OF RAILROAD ENGINEERING J. H. HARRIS	
87. SIGNATURE OF TRANSPORTATION ENGINEERING J. H. HARRIS		88. SIGNATURE OF COMMUNICATIONS ENGINEERING J. H. HARRIS	
89. SIGNATURE OF ELECTRONIC ENGINEERING J. H. HARRIS		90. SIGNATURE OF ELECTRICAL ENGINEERING J. H. HARRIS	
91. SIGNATURE OF MECHANICAL ENGINEERING J. H. HARRIS		92. SIGNATURE OF CIVIL ENGINEERING J. H. HARRIS	
93. SIGNATURE OF ARCHITECTURE J. H. HARRIS		94. SIGNATURE OF LAND SURVEYING J. H. HARRIS	
95. SIGNATURE OF CONSTRUCTION J. H. HARRIS		96. SIGNATURE OF MINING ENGINEERING J. H. HARRIS	
97. SIGNATURE OF METALLURGICAL ENGINEERING J. H. HARRIS		98. SIGNATURE OF CHEMICAL ENGINEERING J. H. HARRIS	
99. SIGNATURE OF INDUSTRIAL ENGINEERING J. H. HARRIS		100. SIGNATURE OF AERONAUTICAL ENGINEERING J. H. HARRIS	

3465

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>17</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Evelyn</u> Middle <u>Marie</u> Last <u>Chilson</u>		4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>Ca</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/18/54</u>
9. AGE (In years lost birthday) <u>5</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Takoma Park, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest H. Chilson</u>		14. MOTHER'S MAIDEN NAME <u>Helen A. Anderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hosp. Records.</u> Address <u>W. 5 H.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interstitial Pneumonia (Virus)</u> 492x DUE TO <u>Generalized Lymphadenopathy (Virus)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>Several hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mongolism</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 11, 1958</u> to <u>March 18, 1960</u> , that I last saw the deceased alive on <u>Dec 5, 1958</u> , and that death occurred at <u>3:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip E. Jones</u>		ADDRESS (Street, city or town, state) <u>918 Ellsworth Drive Silver Spring, Md</u>	
PHYSICIAN'S NAME (Type) <u>Philip E. Jones</u>		DATE SIGNED <u>3/18/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 22, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		ADDRESS <u>254 Carroll St. D.W.</u>	
24a. REC'D BY REGISTRAR <u>MAR 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Knepp</u>	

1

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/58

CERTIFICATE OF DEATH

333

1

[Faint, illegible text and markings on the certificate form, including fields for name, date, and cause of death.]



3466

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hospital</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hospital</u>				d. STREET ADDRESS <u>12203 Grandview Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Angelo Chipouras</u>				4. DATE OF DEATH Month Day Year <u>3 - 29 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-23-16</u>	
9. AGE (In years lost birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant Manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>			
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Angelo Chipouras</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Ziavras</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Army WW2</u>				16. SOCIAL SECURITY NO. <u>578-07-3323</u>			
17. INFORMANT <u>Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO <u>HYPERTENSIVE & ARTERIOSCLEROTIC</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HEART DISEASE</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>1 YEAR</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BRONCHIAL ASTHMA</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8/10</u> , 19 <u>59</u> , to <u>3/29</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/28</u> , 19 <u>60</u> , and that death occurred at <u>4:50</u> A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <u>6727 16th St</u> DATE SIGNED <u>3/29/60</u>			
ACTUAL SIGNATURE <u>David Goldenberg</u> M.D.				PHYSICIAN'S NAME (Type) <u>DAVID GOLDENBERG</u> <u>WASHINGTON, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/31/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u> ADDRESS <u>2901-14 St. N.W. Washington D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 30 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

To be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

CERTIFICATE OF DEATH

State of Maryland
County of Prince George's
I, the undersigned, being a duly qualified medical officer of health for the County of Prince George's, do hereby certify that on the 14th day of April, 1984, at the residence of the deceased, the following named person died:

Name of Deceased: Johnnie S. Jones
Age: 47 years
Sex: Male
Race: White
Usual Residence: 1234 5th St., Prince George's, Md.
Cause of Death: Myocardial Infarction
Immediate Cause: Heart Attack

Signature of Medical Officer: _____
Signature of Registrar: _____
Date: 4/15/84
Place: Prince George's, Md.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3535 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03430

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN lb <u>15 minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montgomery County General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Chrobot</u> Last <u>Chrobot</u>				4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/25/1900</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Const.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Lawrence Chrobot</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-09-1348</u>		17. INFORMANT <u>Mabel Chrobot, (wife) Burtonsville, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u> </u>		(County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> EXAMINER'S NAME (Type) <u>Frank J. Broschart, M. D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>3/25/60</u> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-28-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Rockville, Md.</u>			
23. FUNERAL DIRECTOR <u>Francis H. Barber</u> ADDRESS <u>Laytonsville, Md.</u>				24a. REC'D BY REGISTRAR <u>MAR 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

2

03

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3536
CERTIFICATE OF DEATH

03431

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Blair</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gaithersburg</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Montgomery Co. gen. Hlth. Cntr., Md</i>		d. STREET ADDRESS <i>108 Floral Drive</i>	
3. NAME OF DECEASED (Type or print) <i>Rose Carter Claggett</i>		4. DATE OF DEATH <i>March - 27 - 1960</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-9-1880</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house - keeping</i>		9b. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>	
10. BIRTHPLACE (State or foreign country) <i>Va.</i>		11. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
12. FATHER'S NAME <i>James W. Bailey</i>		13. MOTHER'S MAIDEN NAME <i>Barbara Ellen Hells</i>	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		15. SOCIAL SECURITY NO. <i>108 Floral Dr., Gaithersburg, Md</i>	
16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral accident, (left hemiplegia)</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		17. INTERVAL BETWEEN ONSET AND DEATH <i>40 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes, Asphrosia</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Feb - 16, 1960</i> to <i>March 27, 1960</i> , that (I) (we) last saw the deceased alive on <i>3-27-1960</i> , and that death occurred at <i>6:30 P</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>William C. Miller</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>WILLIAM C. MILLER</i>		22d. ADDRESS <i>1 BROOKS AVEN. GAITHERSBURG</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>3/30/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Joshua</i>		23d. LOCATION (City, town, or county) (State) <i>Gaithersburg Maryland</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Emmett C. Garton</i>		25. REC'D BY REGISTRAR <i>Arthur S. Krause</i>	
25a. ADDRESS <i>Gaithersburg, Md</i>		25b. REGISTRAR'S SIGNATURE	
25c. DATE <i>MAR 30 '60</i>		25d. REGISTRAR'S SIGNATURE	

Amherst, Mass.

2-27-55

William Miller

William C. Miller, Jr. - 1923

62-1511

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 1835 Phelps Place, NW e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Chester Middle Wells Last Clark		4. DATE OF DEATH Month March Day 13 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 5, 1896
9. AGE (In years last birthday) 64		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) C.I.A. Agent	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frederick Clark		14. MOTHER'S MAIDEN NAME Adelaide Knight	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia with atelectasis Cerebral vascular accident DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 600.0 (b) Hypertensive Cardiovascular Disease DUE TO Hypertensive Cardiovascular Disease Due to Chronic Renal Disease Pyelonephritis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (20) 10 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 11 , 19 60 , to March 13 , 19 60 that I last saw the deceased alive on March 13 , 19 60 , and that death occurred at 3:55A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3/13/60			
ACTUAL SIGNATURE CA Chidsey		M.D. The Clinical Center	
PHYSICIAN'S NAME (Type) Charles A. Chidsey, M.D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	22b. DATE THEREOF 3/14/60	22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY	22d. LOCATION (City, town, or county) (State) SUITLAND, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE Joseph G. Gowers Sons		ADDRESS 1736 Penna Ave NW	
24a. REC'D BY REGISTRAR DATE MAR 15 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

325

University of California

Northridge

San Francisco

2 days

San Francisco

1535 Illinois Street, N.W.

The Clinical Center, Bethesda, Md.

40

13

March

Clark

Klein

Chesler

February 2, 1966

White

Klein

7.2.4.

Ohio

Government

U.S. Army

Abolition Society

Proctor & Clark

The Medical Record

The Clinical Center, Bethesda, Md.

None

IV-10 I

Yes

1 week

General venereal symptoms

2 years

Chronic renal disease

10 years

Chronic renal disease

60 March 13

1966

The Clinical Center
Bethesda, Md.

CH-10

Charles A. Klein

U.S. Army

U.S. Army

General Venereal Symptoms

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
3538
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
03433
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 2½ hrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 5904 Crawford Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Baby Boy CLEMENT				4. DATE OF DEATH Month Day Year March 25 1960											
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-25-60		9. AGE (In years lost birthday) yrs. Months Days 2 29		10. IF UNDER 1 YEAR Months Days 2 29		11. IF UNDER 24 HRS. Hours Min. 2 29			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY - - - - -				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Billy M. CLEMENT						14. MOTHER'S MAIDEN NAME Sarah K. USSERLY									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None				17. INFORMANT (F) Billy M. Clement, same as #2 above				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Primary atelectasis DUE TO (c) Immaturity (1# 2 oz) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 ½ hrs 2 ½ hrs always												INTERVAL BETWEEN ONSET AND DEATH 2 ½ hrs 2 ½ hrs always			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)														20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While o. m. p. m. of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (the hospital) attended the deceased from 3/25 19 60 to 3/25 19 60 , that (I) (we) last saw the deceased alive on 3/25 19 60 , and that death occurred at 1005A AM, from the causes and on the date stated above.															
22a. SIGNATURE G. B. Avery						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-25-60							
22c. PHYSICIAN'S NAME (Type) G. B. AVERY, LT, MC, USN						22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial - Ship				23b. DATE THEREOF 3-26-60		23c. NAME OF CEMETERY OR CREMATORY Norwood Cemetery				23d. LOCATION (City, town, or county) (State) Norwood, Stanley Co. N.C.					
24. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey						ADDRESS 7551 WINE AVE		25a. REC'D BY REGISTRAR MAR 28 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline					
24. FUNERAL HOME R.A. Pumphrey Funeral Home, Bethesda, Md.															

2051383XV0

(12.12)

22

References

1990

Order Code 400234 (9-11-01)

U. S. Naval Institute, Annapolis, Md.

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3539

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 31 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 560 23rd Place, N. E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Millie Middle (None) Last Conn				4. DATE OF DEATH Month March Day 19 Year 19 60			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 18, 1879	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 80 Days 80 Hours 80 Min.		IF UNDER 24 HRS. Months 80 Days 80 Hours 80 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Louisiana	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME William Williams				14. MOTHER'S MAIDEN NAME Willie Ann (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Unascertainable			
17. INFORMANT The Medical Record				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory depression DUE TO Post-operative intestinal obstruction, and pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1. local pelvic invasion by cancer with intra-abdominal metastases 2. epidermoid carcinoma of the cervix (c) 17 days 6 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 171x							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from February 17, 19 60 to March 19, 19 60 that I last saw the deceased alive on March 19, 19 60 , and that death occurred at 7:30 PM , from the causes and on the date stated above. Marvin S. Arons ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3/20/60 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) 3-23-60				22b. DATE THEREOF 3-23-60		22c. NAME OF CEMETERY OR CREMATORY new Harmony	
22d. LOCATION (City, town, or county) (State) P. S. Co. Md							
23. FUNERAL DIRECTOR'S SIGNATURE Barnes & Matthews				ADDRESS 3619-14th St. N.W.		24a. REC'D BY REGISTRAR DATE MAR 22 '60	
24b. REGISTRAR'S SIGNATURE William S. Kenna							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of Columbia

Washington

21 days

Station

The Clinical Center, Bethesda, Md.

500 2nd Street, N.E.

(Room)

Wells

August 18, 1972

Female

Location

One

Concise

William Williams

White and Johnson

The National Center

Immunization Clinical Center, Bethesda, Md.

Respiratory depression

Post-operative intestinal obstruction, and

menstruation

A local police investigation by cancer with later-

specimens to be used in a separate study of

the cervix

February 17, 1973

March 29, 1973

William G. Cray

The National Center

National Immunization of

Bethesda, Md., Maryland

William G. Cray, M.D.

3467

CERTIFICATE OF DEATH

03434

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		d. STREET ADDRESS 5031 Nantucket Road	
3. NAME OF DECEASED (Type or print) First Middle Last Collins		4. DATE OF DEATH Month Day Year March 9 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 9, 1960
9. AGE (In years lost birthday) yrs. 6		10. IF UNDER 1 YEAR Months Days 6	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clyde Eugene Collins		14. MOTHER'S MAIDEN NAME Leona Freida Greeney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Father - 5031 Nantucket Road, College Pk, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Pulmonary Disease 763.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 hr. 46 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 1:14pm March 9 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/9 , 19 60 , to 3/9 , 19 60 , that I last saw the deceased alive on 8:30 AM 3/9 , 19 60 , and that death occurred at 1:14pm , from the causes and on the date stated above.			
ACTUAL SIGNATURE Murray Paul		ADDRESS (Street, city or town, state) 8106 New Hampshire Ave., L.Pk., Md.	
PHYSICIAN'S NAME (Type) Murray Paul, M.D.		DATE SIGNED 8106 New Hampshire Ave., Langley, Park, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF March 9, 1960	22c. NAME OF CEMETERY OR CREMATORY Washington San. & Hospital Takoma Park, Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M.D. Wash. San. & Hospital		24a. REC'D BY REGISTRAR MAR 18 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Nov 4/160

2075386XV5

CHURCH OF CHAIR

James Wright

William

Monroe

William

James

William

William

March 2, 1960

White

James

U.S.A.

William

James

James

James - 2011 William at Road, College, N.Y.

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James - 2011 William at Road, College, N.Y.

James - 2011 William at Road, College, N.Y.

03436

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years, last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTERSTITIAL (VIRUS) PNEUMONIA</u> 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/30, 1958, to 3/10/1960, that I last saw the deceased alive on 3/9/1960, and that death occurred at 8:12 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED			
ACTUAL SIGNATURE		M.D.					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE			

CERTIFICATE OF DEATH

STATE OF MARYLAND - BALTIMORE

1913

WILSON

WILSON



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3540

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 13, 14 Film G258 3-10-60 et

03437

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE District of Columbia b. COUNTY Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		d. STREET ADDRESS 1705 Lanier Place, N. W.	
3. NAME OF DECEASED (Type or print) First BLANCHE Middle HOLBROOK Last CROISSANT		4. DATE OF DEATH Month March Day 3 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1875
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 8 Days 4	IF UNDER 24 HRS. Hours 17 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) New York.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Daughter Mrs. Irwin H. Wensink		Address 4700 Langdrum La., Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 902.5 DUE TO Fracture, Left hip Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 days DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 17 hours			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from high curb attempting to take a bus.	
20c. TIME OF INJURY Month, Day, Year 3-1-1960 Hour 11:30 a. m. pm.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Wis. Ave. & D. C. Line, Bethesda, Montg. Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED Mar. 3, 1960	
EXAMINER'S NAME (Type) FRANK J. BROSCHART		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/5/60	
22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR Mar 7 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

3541

CERTIFICATE OF DEATH

03438

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cornelia Middle H. Last Cruikshank		4. DATE OF DEATH Month March Day 1 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/15/77
9. AGE (In years lost birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Evanston, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Holdbird		14. MOTHER'S MAIDEN NAME M aria Augue	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mrs. M ary Kyster (Daughter)		Address Same as Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cardiovascular accident Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 15 , 19 60 , to March 1 , 19 60 , that I last saw the deceased alive on March 1 , 19 60 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr Joseph Kenrick		ADDRESS (Street, city or town, state) 6450 Wisconsin Ave, Bethesda, Md. DATE SIGNED 3/1/60	
PHYSICIAN'S NAME (Type) Jos. P. Kenrick			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF MAR. 4, 1960	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	22d. LOCATION (City, town, or county) (State) ARLINGTON VA.
23. FUNERAL DIRECTOR'S SIGNATURE Charles Edward Hines ADDRESS 816 N St NE Wash D.C.		24a. REC'D BY REGISTRAR MAR 4 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CENTRAL OF DEATH

3221

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3542
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 5 1/2 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle Last Davis		4. DATE OF DEATH Month 3 Day 1 Year 1960	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 10, 1885
9. AGE (In years last birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles H. Davis	
14. MOTHER'S MAIDEN NAME Mary Jenkins		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. no		17. INFORMANT Sister - Mrs. Susan Horn	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Butatinal confluent bronchopneumonia DUE TO (b) 2 days DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 29 February, 1960 , to 29 February 1960 , that I last saw the deceased alive on 29 February, 1960 , and that death occurred at 4:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward S. Witowski, Jr. M.D.		ADDRESS (Street, city or town, state) Suite 400, 8218 Wisconsin Ave., Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Edward S. Witowski, Jr.		DATE SIGNED 3/1/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/5/60	22c. NAME OF CEMETERY OR CREMATORY Ash Memorial,	22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Shanderson		24a. REC'D BY REGISTRAR MAR 8 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

CERTIFICATE OF DEATH

Place of Birth

Interment

Signature

Henry

Married

White

Residence

Charles H. Davis

Mary Jackson

Age

John - Mrs. John Davis

In. Faculty No. 1

3543

CERTIFICATE OF DEATH

03440

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
c. LENGTH OF STAY IN 1b 49 days				d. STREET ADDRESS 30 Hamilton St. N.W.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Atkinson Last DAVIS				4. DATE OF DEATH Month March Day 21 Year 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-6-09	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME James DAVIS				14. MOTHER'S MAIDEN NAME Adela ABLES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 1948-1946		INFORMANT (Wife) Dorothy M. Davis	
Address Same as #2				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma, cecum, with metastases 153.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 4 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 February , 19 60 , to 21 March , 19 60 , that I last saw the deceased alive on 21 March , 19 60 , and that death occurred at 11:35A , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>R. C. Thomas</i>				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) R. C. THOMAS, LT., MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-25-60		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S NAME (Type) Robert S. McGuire				ADDRESS 9th and S Street N.W. Washington, D.C.		24a. REC'D BY REGISTRAR MAR 24 '60	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>							

1. *Journal of the American Medical Association*, 1997; 277: 1001-1005.

• • •

1. The first part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03441

3437

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 9 1/2 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12,814 Holdridge Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDITH Middle E. Last DICKENS				4. DATE OF DEATH Month MARCH Day 19 Year 19 60			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 21, 1887		9. AGE (In years lost birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Winfield Colburn				14. MOTHER'S MAIDEN NAME Ella Burch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Charles C. King, 5501 North Capital St.				Address Washington, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malabsorptive Syndrome 545 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gastroscolostomy Spontaneous DUE TO (c) Malfunctioning gastrojejunostomy							INTERVAL BETWEEN ONSET AND DEATH 2 yrs 2 yrs 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from June 19 45 to 3 19 19 60 that (I) (we) last saw the deceased alive on 3 17 19 60 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE Samuel M. Bageant				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) SAMUEL M. BAGEANT				22d. ADDRESS 5600 N.H. Ave. Wash., D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/22/60		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.				ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR DATE MAR 22 '60	
25b. REGISTRAR'S SIGNATURE William L. Evans							

CERTIFICATE OF DEATH

3231

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

DATE OF BIRTH

TIME OF DEATH

PLACE OF BIRTH

SEX

DATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

DATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

3544										03442																													
1. PLACE OF DEATH										2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)																													
a. COUNTY					Montgomery					a. STATE					b. COUNTY																								
b. CITY OR TOWN (If outside corporate limits, write nearest town)					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					Suburban Hospital					d. STREET ADDRESS					5453 Nebraska Ave. NW																								
3. NAME OF DECEASED (Type or print)					Grace F Dietrick					4. DATE OF DEATH					March 24 19 60																								
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.																											
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9-10-91		68 yrs.		Months Days Hours Min.																													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country)					12. CITIZEN OF WHAT COUNTRY?																								
none					none					Pennsylvania					d. S. A.																								
13. FATHER'S NAME					Charles Bauer					14. MOTHER'S MAIDEN NAME					Sibert																								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.					17. INFORMANT					Address																								
no					no					Paul G. Dietrick (52me)																													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH																													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										426.1 Anterior myocardial infarction and beginning dissecting aortic aneurysm										24 hrs.																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										DUE TO (b)																													
										DUE TO (c)										Arteriosclerosis, generalized										10 yrs.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										Essential hypertension										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																																		
20c. TIME OF INJURY Month, Day, Year					20d. INJURY OCCURRED					20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)																								
Hour a. m. p. m.					While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>																																		
21. I certify that (I) (this hospital) attended the deceased from Feb. 1947, to March 24, 1960, that (I) (we) last saw the deceased alive on 3:24 PM, 1960, and that death occurred at 4:17 PM, from the causes and on the date stated above.																																							
22a. SIGNATURE					Stewart Clapp					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED 3.24.60																								
22c. PHYSICIAN'S NAME (Type)					Stewart Clapp					22d. ADDRESS					3921 Ingomar St NW Wash DC																								
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE THEREOF					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City, town, or county) (State)																								
removal					3/28/60					Mt. Greenwood Cem.					Luzerne County Shavertown, Pa.																								
24. FUNERAL DIRECTOR'S SIGNATURE										ADDRESS										25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE														
Theodore H. Hensler										2901-14th St NW										MAR 28 '60					C. Hensler														

CERTIFICATE OF DEATH

MARYLAND DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS

10425

10425

1. Name of Deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of Birth: *10/15/1920*

5. Date of Death: *11/10/1965*

6. Place of Birth: *Washington, D.C.*

7. Place of Death: *Home*

8. Cause of Death: *Heart Disease*

9. Signature of Physician: *[Signature]*

10. Signature of Registrar: *[Signature]*

11. Date of Registration: *11/15/1965*

12. Office of Registrar: *State of Maryland*

10425

3545

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bessie Middle R. Last Dimes				4. DATE OF DEATH Month 3 Day 5 Year 19 60			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/7/02	9. AGE (In years lost birthday) 58 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph Cooper				14. MOTHER'S MAIDEN NAME Anna Rebecca Lyles			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. unknown		INFORMANT Dorothy Cooper Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral infarction 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Cerebral thrombosis DUE TO (c) Cerebral arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Recent myocardial infarction 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 3-2 , 19 60 , to 3-5 , 19 60 , that I last saw the deceased alive on 3-5 , 19 60 , and that death occurred at M , from the causes and on the date stated above. ACTUAL SIGNATURE W. J. Doyon M.D. ADDRESS (Street, city or town, state) 8106 Maple Ridge Rd Bethesda, Md DATE SIGNED 3/6/60 PHYSICIAN'S NAME (Type) W. J. Doyon							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/9/60		22c. NAME OF CEMETERY OR CREMATORY Lincoln Park.		22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Anawald ADDRESS Rockville, Md.				24a. REC'D BY REGISTRAR DATE MAR 8 '60		24b. REGISTRAR'S SIGNATURE Wilbur S. Hays	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

5000

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

10

3546

CERTIFICATE OF DEATH

03444

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Princes Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum Hts. Hyattsville, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 5710 Chillum Hts. Drive	
3. NAME OF DECEASED (Type or print) First EDWARD Middle G. Last DOBY		4. DATE OF DEATH Month 3 Day 14 Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5/22/07
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sub-Layer		10b. KIND OF BUSINESS OR INDUSTRY M.C.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Doby		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W.# 2	
17. INFORMANT Mona T. Doby, Ex-wife		Address 1105 E. Capitol St. Wash, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 Week 8 Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June , 19 50 , to March 14 , 19 60 , that I last saw the deceased alive on 3-14 , 19 60 , and that death occurred at 3 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4201 Fessenden St NW DATE SIGNED ACTUAL SIGNATURE P.P. Andrews M.D. 4201 Fessenden St NW PHYSICIAN'S NAME (Type) P.P. ANDREWS M.D. Washington A.C. 3-14-60			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 3/17/60	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.		24a. REC'D BY REGISTRAR DATE MAR 16 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Hines

Dr. Brochart Notified

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3547 CERTIFICATE OF DEATH

1. Name of Deceased: JOHN J. BROWN

2. Sex: Male

3. Race: White

4. Date of Birth: 10/15/1890

5. Date of Death: 11/10/1960

6. Place of Birth: Baltimore, Md.

7. Usual Residence: 1234 Elm St., Baltimore, Md.

8. Cause of Death: Myocardial Infarction

9. Duration of Illness: 2 weeks

10. Place of Death: Home

11. Signature of Physician: [Signature]

12. Signature of Registrar: [Signature]

13. Date of Registration: 11/15/1960

FILED - BALTIMORE, MD.

3547

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>DOERN</u> Last <u>DOERN</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 20, 1869</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9c. AGE (In years last birthday) <u>90</u> yrs. IF UNDER 1 YEAR Months <u>6</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Humphrey Falvey</u>	
14. MOTHER'S MARDEN NAME <u>Catherine Fitzpatrick</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>INFORMANT</u>		17. ADDRESS <u>Daughter Bertha D. PETERS SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchogenic carcinoma left lung</u> DUE TO (c) <u>unknown</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease with congestive failure</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>FEB 15</u> , 19 <u>60</u> , to <u>3/13</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/13/60</u> , 19 <u>60</u> , and that death occurred at <u>5:30</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr J Kenrick</u>		ADDRESS (Street, city or town, state) <u>6450 Wisconsin Ave, Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Dr JOSEPH KENRICK</u>		DATE SIGNED <u>3/13/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/16/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Agnes Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Bethesda, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chung Chae</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Frank</u>	
ADDRESS <u>5105 Reservoir Road, N.W.</u>		DATE <u>MAR 18 '60</u>	

CERTIFICATE OF TAXATION

381

No. 1		Date	
1913		Jan 1	
1914		Jan 1	
1915		Jan 1	
1916		Jan 1	
1917		Jan 1	
1918		Jan 1	
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CERTIFICATE OF DEATH

Reg. Dist. No.

03446

3548

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 86 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase d. STREET ADDRESS 7709 Chatham Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Robert John Dorr		4. DATE OF DEATH Month March Day 23 Year 1960					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 13, 1919	9. AGE (In years lost birthday) yrs. 40	10. IF UNDER 1 YEAR Months 10		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreign Service Officer		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) California			
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME William R. Dorr		14. MOTHER'S MAIDEN NAME Evelyn A. Corker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unascertainable		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemopericardium with cardio-respiratory failure DUE TO 194X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Primary thyroid carcinoma DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____				INTERVAL BETWEEN ONSET AND DEATH 24 hours 10 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
		20f. (City or town)		(County) (State)			
21. I certify that I attended the deceased from December 28, 1959 to March 23, 1960 that I last saw the deceased alive on March 23, 1960 , and that death occurred at 8:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center Bethesda 14, Maryland DATE SIGNED March 23, 1960							
ACTUAL SIGNATURE Charles E. Mengel		PHYSICIAN'S NAME (Type) Charles E. Mengel, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY			
CREMATION		3/24/60		CEDAR HILL CREMATORY			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Hawley Sons		ADDRESS 1736 R. Ave. N.W. Wash. D.C.		24a. REC'D BY REGISTRAR DATE MAR 28 '60			
				24b. REGISTRAR'S SIGNATURE Arthur S. Kinn			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1955

CERTIFICATE OF DEATH

324

Montgomery Maryland Montgomery

between 50 days Navy Nurse

The Clinical Center, Bethesda II, Md. 1700 Chestnut St.

Robert John Mary 23 60

White November 13, 1909 No

Foreign Service Officer Government California U. S. A.

William H. Fort

Dr. J. A. Conner

The Medical Record
The Clinical Center, Bethesda II, Maryland

Relatives and friends to be notified by letter

Primary thyroid operation

March 23 60

The Clinical Center
National Institutes of Health
Bethesda II, Maryland

CLINICAL CENTER

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3469
CERTIFICATE OF DEATH

03447

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <i>New Jersey</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elizabeth</i> 67X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>075 Washington Sanitarium & Hospital</i>				d. STREET ADDRESS <i>20 Vista Ave.</i>			
3. NAME OF DECEASED (Type or print) First <i>Freda</i> Middle <i>Anna</i> Last <i>Dow</i>				4. DATE OF DEATH Month <i>March</i> Day <i>14</i> Year <i>1960</i>			
5. SEX <i>Fe</i>	6. COLOR OR RACE <i>Cauc</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-22-94</i>	9. AGE (In years lost birthday) <i>65</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>New Jersey</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Carl Schenk</i>				14. MOTHER'S MAIDEN NAME <i>Katherine Roskida</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT Address <i>Washington Sanitarium & Hosp. Records</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hepatic Cancer</i> <i>155.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Carcinoma Cervicis Uteri</i> DUE TO (c) <i>—</i>						INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>4 mos.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Feb 21</i> 19 <i>60</i> to <i>March 14</i> 19 <i>60</i> , that (I) (we) lost <i>saw the deceased alive on</i> 19 <i>60</i> , and that death occurred at <i>—</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>Lyle Williams</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>3/15/1961</i>	
22c. PHYSICIAN'S NAME (Type) <i>LYSLE WILLIAMS</i>				22d. ADDRESS <i>8700 Columbia Pike, Silver Spring, Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>March 18, 1960</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Restland Memorial Park</i>		23d. LOCATION (City, town, or county) (State) <i>East Hanover, New Jersey</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walter</i> ADDRESS <i>254 Cornell St. D.W.</i>				25a. REC'D BY REGISTRAR DATE <i>MAR 16 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

Reg. Dist. No.

03448

3549

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church			
c. LENGTH OF STAY IN 1b 7 days				d. STREET ADDRESS 430 Crosswoods Drive			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Tomas Middle Mateo Last Dreyfuss		4. DATE OF DEATH		Month March Day 1 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 15, 1951		9. AGE (In years last birthday) 8 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John T. Dreyfuss				14. MOTHER'S MAIDEN NAME Janis Behr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Cerebellar and Subarachnoid Hemorrhage. 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Secondary Acute Leukemia DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH days 2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 23, 1960 , to March 1, 1960 , that I last saw the deceased alive on March 1, 1960 , and that death occurred at 1:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 3-1-60							
ACTUAL SIGNATURE Richard C. Mechanic				M.D. The Clinical Center			
PHYSICIAN'S NAME (Type) RICHARD C. MECHANIC, M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-4-1960		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATL		22d. LOCATION (City, town, or county) (State) FT MYER VA	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers				ADDRESS 3072 M St NW		24a. REC'D BY REGISTRAR DATE MAR 3 '60	
						24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CENTRAL BUREAU OF DEATH

10-1-47

Montgomery
Richards
The Clinical Center, Bethesda 14, Md.
Jones
White
September 11, 1951 8

Blanchard
John T. Fryer
The Clinical Center, Bethesda 14, Maryland
Blanchard
John T. Fryer
The Clinical Center, Bethesda 14, Maryland
Blanchard
John T. Fryer
The Clinical Center, Bethesda 14, Maryland

February 23 - 50
March 1 - 50
The Clinical Center
National Institute of Health
Bethesda 14, Maryland

February 23 - 50
March 1 - 50
The Clinical Center
National Institute of Health
Bethesda 14, Maryland

3550

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kentucky b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 14 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Geneva Middle (None) Last Duff		4. DATE OF DEATH Month March Day 13 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 17, 1943
9. AGE (In years last birthday) 16 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Student)		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jimmie Duff		14. MOTHER'S MAIDEN NAME Ethel Everson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO 410X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mitral insufficiency DUE TO (c) Rheumatic fever		INTERVAL BETWEEN ONSET AND DEATH 2 days 14 years 14 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 28, 1960 , to March 13, 1960 that I last saw the deceased alive on March 13, 1960 , and that death occurred at 1:10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE E. C. Brockenbrough, M.D. M.D.		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3/13/60	
PHYSICIAN'S NAME (Type) Edwin C. Brockenbrough, M.D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 3/14/60	
22c. NAME OF CEMETERY OR CREMATORY --		22d. LOCATION (City, town, or county) (State) Hazard, Kentucky	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St. N.W.		24a. REC'D BY REGISTRAR MAR 15 '60	
ADDRESS Washington, D.C.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

MEMORANDUM FOR THE DIRECTOR
SUBJECT: [Illegible]

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3551

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03450

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>9 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>57 Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4721 N. Chelsea Lane</u>				d. STREET ADDRESS <u>4721 Chelsea Ln</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Moort</u> Last <u>DuQuoin</u>				4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-31-1906</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Gov. Int. Rev. Int. Revenue</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Del.</u>		11. BIRTHPLACE (State or foreign country) <u>Ill.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Andrew E. DuQuoin</u>				14. MOTHER'S MAIDEN NAME <u>Kathryn Smoot</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Sister</u> Address <u>Mrs. John Warner-Clinton, Illinois</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Secobarbital poisoning</u> DUE TO <u>970.2</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brosch</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/12/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>MAR 16 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1, 2, and 3 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. SMITH		2. SEX Male		3. AGE 45		4. RACE White	
5. DATE OF DEATH Jan 15, 1924		6. TIME OF DEATH 10:30 A.M.		7. PLACE OF DEATH Home		8. CITY Baltimore	
9. STREET 1234 N. Enoch Ave.		10. CITY Baltimore		11. COUNTY Baltimore		12. STATE Maryland	
13. OCCUPATION Clerk		14. MARITAL STATUS Married		15. EDUCATION High School		16. RELIGION Roman Catholic	
17. CAUSE OF DEATH Myocardial Infarction		18. MANNER OF DEATH Natural		19. SIGNATURE OF EXAMINER J. H. Smith		20. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones	
21. SIGNATURE OF DECEASED J. H. Smith		22. SIGNATURE OF NEAREST RELATIVE J. D. Jones		23. SIGNATURE OF CLERK J. H. Smith		24. SIGNATURE OF NURSE J. D. Jones	
25. SIGNATURE OF PHYSICIAN J. H. Smith		26. SIGNATURE OF CHURCH CLERK J. D. Jones		27. SIGNATURE OF MINISTER J. H. Smith		28. SIGNATURE OF RABBI J. D. Jones	
29. SIGNATURE OF JEWELER J. H. Smith		30. SIGNATURE OF BARBER J. D. Jones		31. SIGNATURE OF COFFIN MAKER J. H. Smith		32. SIGNATURE OF BURIAL PLACE J. D. Jones	
33. SIGNATURE OF FUNERAL HOME J. H. Smith		34. SIGNATURE OF CEMETERY J. D. Jones		35. SIGNATURE OF INTERMENT J. H. Smith		36. SIGNATURE OF BURIAL J. D. Jones	
37. SIGNATURE OF DECEASED J. H. Smith		38. SIGNATURE OF NEAREST RELATIVE J. D. Jones		39. SIGNATURE OF CLERK J. H. Smith		40. SIGNATURE OF NURSE J. D. Jones	
41. SIGNATURE OF PHYSICIAN J. H. Smith		42. SIGNATURE OF CHURCH CLERK J. D. Jones		43. SIGNATURE OF MINISTER J. H. Smith		44. SIGNATURE OF RABBI J. D. Jones	
45. SIGNATURE OF JEWELER J. H. Smith		46. SIGNATURE OF BARBER J. D. Jones		47. SIGNATURE OF COFFIN MAKER J. H. Smith		48. SIGNATURE OF BURIAL PLACE J. D. Jones	
49. SIGNATURE OF FUNERAL HOME J. H. Smith		50. SIGNATURE OF CEMETERY J. D. Jones		51. SIGNATURE OF INTERMENT J. H. Smith		52. SIGNATURE OF BURIAL J. D. Jones	

RECEIVED
JAN 16 1924
BALTIMORE, MD.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03451

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BURTONSVILLE c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BURTONSVILLE d. STREET ADDRESS 2711 DUVALL ROAD e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES LEWIS DUVALL				4. DATE OF DEATH Month Day Year MARCH 4 19 60															
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/29/84		9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY Farm				11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME WILLIAM SPENCER DUVALL				14. MOTHER'S MAIDEN NAME SARA ANNA ROCH				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT HOSPITAL RECORDS Address OLNEY, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ANEMIA DUE TO 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ADENOCARCINOMA OF PROSTATE WITH METASTASES DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS 2 YEARS												PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 10/25/59, 19 to 3/4/60, 19, that (I) (we) last saw the deceased alive on 2/22/60, 19, and that death occurred at 1:35 PM, from the causes and on the date stated above.																			
22a. SIGNATURE G. H. LIGON, M. D.				22b. DATE SIGNED 3/4/60				22c. PHYSICIAN'S NAME (Type) G. H. LIGON, M. D.				22d. ADDRESS SANDY SPRING, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 3/7/60		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery				23d. LOCATION (City, town, or county) Burtonsville Md									
24. FUNERAL DIRECTOR'S SIGNATURE De Witt Sanablan, Laurel, Md				25a. REC'D BY REGISTRAR DATE MAR 10 '60				25b. REGISTRAR'S SIGNATURE Arthur S. Hines											

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Place of birth: [illegible]
6. Date of death: [illegible]
7. Place of death: [illegible]
8. Cause of death: [illegible]
9. Signature of physician: [illegible]
10. Signature of registrar: [illegible]
11. Date of registration: [illegible]

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3508

CERTIFICATE OF DEATH

03452

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN 1b 47X-3 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 2022 Naylor Rd. S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANK Middle H. Last DUVALL		4. DATE OF DEATH Month MARCH Day 12 Year 1960	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-19-73
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 86 Days 86 Hours 86 Min.	11. IF UNDER 24 HRS. Months 86 Days 86 Hours 86 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Duvall		14. MOTHER'S MAIDEN NAME Mary ??	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 578-10-8546	
17. INFORMANT Mrs Dora C Duvall		Address -2022 Naylor Rd S.E.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 445X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ESSENTIAL HYPERTENSION DUE TO (c) GENERALIZED ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from AUG. 13, 1958 to MARCH 12, 1960 , that I last saw the deceased alive on MARCH 12, 1960 , and that death occurred at 10:50 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Meagen Fordice M.D.		ADDRESS (Street, city or town, state) 5206 Naylor, D.C. DATE SIGNED 3/12/60	
PHYSICIAN'S NAME (Type) Cheng Chang, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-15-60	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Suitland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington, D.C.		24. REC'D BY REGISTRAR DATE MAR 15 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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DATE OF BIRTH

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CERTIFICATE OF DEATH

Reg. Dist. No.

03453

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>7da.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alice Barnes Edwards</u>				4. DATE OF DEATH Month Day Year <u>March 31 19 60</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-21-75</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Barnes</u>				14. MOTHER'S MAIDEN NAME <u>Alice Burkes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT Address <u>Alice E. Woble, 5715 Arundel Ave. Rockville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis, generalized</u> DUE TO (c) <u>Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 24, 1960</u> to <u>March 31, 1960</u> that I last saw the deceased alive on <u>March 31, 1960</u> , and that death occurred at <u>6:38 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Bowditch Hunter, Jr. M.D.</u>				ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd. Rockville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>G. Bowditch Hunter, Jr.</u>				DATE SIGNED <u>3/31/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-2-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>ROBERT A. PUMPHREY Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>APR 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>C. J. Jones</u>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03454

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Mont.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>22 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Jessie</i> First <i>Elizabeth</i> Middle <i>Emmert</i> Last		4. DATE OF DEATH Month <i>3</i> - Day <i>24</i> - Year <i>1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-5-04</i>
9. AGE (In years last birthday) <i>55</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Grad Nurse</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S. g.</i>	
13. FATHER'S NAME <i>John Rider</i>		14. MOTHER'S MAIDEN NAME <i>Florence Shaver</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>577-52-0350</i>	
17. INFORMANT <i>Washington Sanitarium + Hospital Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Broncho Pneumonia</i> DUE TO <i>570.5</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <i>Partial Bowel Obstruction</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i> <i>6 Months.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>12/8/59</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>12/8/59</i> to <i>3/24/60</i> , that (I) (we) last saw the deceased alive on <i>3/24/60</i> , and that death occurred at <i>6:55 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>H. T. Morse</i>		22b. DATE SIGNED <i>Mar. 24, 1960</i>	
22c. PHYSICIAN'S NAME (Type) <i>H. T. MORSE</i>		22d. ADDRESS <i>7030 Carroll Ave., Takoma Park, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>3-25-60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		23d. LOCATION (City, town, or county) (State) <i>Prince George Co., Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>ROBERT A. PUMPHREY</i>		ADDRESS <i>Bethesda, Md.</i>	
25a. REC'D BY REGISTRAR <i>Mar 28 '60</i>		25b. REGISTRAR'S SIGNATURE <i>C. L. S. K...</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03455

Reg. Dist. No.

3554

1. PLACE OF DEATH a. COUNTY Mont MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 57 Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5314 Baltimore Ave.		d. STREET ADDRESS 15314 Baltimore Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARGARET Middle E' Last WE		4. DATE OF DEATH Month MARCH Day 27 Year 1960	
5. SEX 7	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 June 1880
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis H. Barrett		14. MOTHER'S MAIDEN NAME Annie Price	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. none	
17. INFORMANT David L. E'We, 5314 Balto. Ave. Bethesda		Address Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) congestive heart failure 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 10 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 21 Mar., 1960 , to 27 Mar., 1960 , that I last saw the deceased alive on 26 Mar., 1960 , and that death occurred at 3:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5029 Bethesda Ave Bethesda Md DATE SIGNED 27 Mar 60			
ACTUAL SIGNATURE Herbert Martyn Jr		M.D. 5029 Bethesda Ave Bethesda Md	
PHYSICIAN'S NAME (Type) HERBERT MARTYN JR			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 3/28/1960	
22c. NAME OF CEMETERY OR CREMATORY Zion		22d. LOCATION (City, town, or county) (State) Northfield, N.J.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Truitt Smith		ADDRESS 1756 Pa. Ave. NW DC	
24a. REC'D BY REGISTRAR MAR 29 60		24b. REGISTRAR'S SIGNATURE Arthur S. Miller	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Journal of Management Studies 37(1): 1-16

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CERTIFICATE OF DEATH

Reg. Dist. No.

03456

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>Since 2/2/1959</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ellen</u> Last <u>Forney</u>		4. DATE OF DEATH Month <u>3</u> Day <u>38</u> Year <u>1968</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/18/1884</u>
9. AGE (In years lost birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>10</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Wash D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James O'Brien</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret Hughes</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>	
16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Margaret Wynkoop</u> Address <u>6421 Broad St Bethesda</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis with slowly progressive deterioration</u> 334X DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <u></u> DUE TO (d) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>14 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u></u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) <u></u> (County) <u></u> (State) <u></u>
21. I certify that I attended the deceased from <u>August 16, 1954</u> , to <u>March 28, 1960</u> , that I lost saw the deceased alive on <u>March 28, 1960</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Allen J. O'Neill</u> M.D.		ADDRESS (Street, city or town, state) <u>8601 old Leargetown Rd Bethesda 14 MD</u>	
PHYSICIAN'S NAME (Type) <u>Allen J. O'Neill</u>		DATE SIGNED <u>APR 1 '60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-31-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don. DeVol</u>		24a. REC'D BY REGISTRAR <u>WASH.</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hines</u>	
ADDRESS <u>2224 Wisconsin N.W. D.C.</u>		DATE <u>APR 1 '60</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3504

CERTIFICATE OF DEATH

Reg. Dist. No.

03457

1. PLACE OF DEATH a. COUNTY Gaithersburg Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montg			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg. Md				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg. (Rural)			
c. LENGTH OF STAY IN 1b 7				d. STREET ADDRESS R F D #3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rest Haven Rest Home,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Turner Middle Jackson Last Foster				4. DATE OF DEATH Month Mar Day 28 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 18-1880	
9. AGE (In years lost birthday) 79 yrs.		IF UNDER 1 YEAR Months 7 Days 10		IF UNDER 24 HRS. Hours 10 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Limeton Va,	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Warner R. Foster				14. MOTHER'S MAIDEN NAME Martha Beam			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO. William J. Foster. Gaithersburg. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure. 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Vascular Accident DUE TO (c) (Brain Hemorrhage)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb , 19 60 , to March 28 , 19 60 , that I last saw the deceased alive on 3/28 , 19 60 , and that death occurred at 9:30 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Gaithersburg, Md DATE SIGNED ACTUAL SIGNATURE Luciano I. Leal M.D. PHYSICIAN'S NAME (Type) Luciano I. Leal M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3/30/60		22c. NAME OF CEMETERY OR CREMATORY Park Lawn	
22d. LOCATION (City, town, or county) (State) Rockville. Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus				24. REC'D BY REGISTRAR DATE MAR 30 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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Coronary Artery Disease
(see summary)

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CERTIFICATE OF DEATH

Reg. Dist. No.

03458

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Indiana b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 144 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Route # 1			
3. NAME OF DECEASED (Type or print) First Fauneil Middle Garaldene Last Fox				4. DATE OF DEATH Month March Day 24 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 18, 1913		9. AGE (In years lost birthday) yrs. 46	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Willis Oland				14. MOTHER'S MAIDEN NAME Eva James			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 316-26-2028		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 195.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Adrenal Cortical Carcinoma DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 5 Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 1, 1959 to March 24, 1960 , that I last saw the deceased alive on March 24, 1960 , and that death occurred at 6:50a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3-24-60 ACTUAL SIGNATURE Gordon C. Sharp M.D. The Clinical Center PHYSICIAN'S NAME (Type) GORDON C. SHARP, M.D. National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 3/25/60		22c. NAME OF CEMETERY OR CREMATORY West Lebanon		22d. LOCATION (City, town, or county) (State) Warren County, Indiana	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE MAR 28 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraw			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES DEPARTMENT OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3557

CERTIFICATE OF DEATH

Reg. Dist. No.

03459

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 17 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
1. NAME OF DECEASED (Type or print) First Lynne Middle Beth Last Freedman		4. DATE OF DEATH Month March Day 6 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1949
9. AGE (In years lost birthday) yrs. 10		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Student)		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME David Freedman		14. MOTHER'S MAIDEN NAME Irene Brownman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra-Abdominal Hemorrhage from Metastases DUE TO Adrenal Cortical Carcinoma with Metastases to Peritoneal Cavity, Liver and Lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Peritoneal Cavity, Liver and Lungs DUE TO (c) Peritoneal Cavity, Liver and Lungs		INTERVAL BETWEEN ONSET AND DEATH Hours 7 Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe Cachexia		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 18, 1960 , to March 6, 1960 , that I last saw the deceased alive on March 6, 1960 , and that death occurred at 3:35 p. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John Leeman Lewis, Jr.		ADDRESS (Street, city or town, state) The Clinical Center	
PHYSICIAN'S NAME (Type) JOHN LEEMAN LEWIS, JR.		DATE SIGNED 3-6-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAR. 7, 1960	
22c. NAME OF CEMETERY OR CREMATORY ELESABETGRAD CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY & SONS - 3501-14th St. N.W.		24a. REC'D BY REGISTRAR DATE MAR 8 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

Montgomery

Lawrence

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

Montgomery

Driver's License

17 days

between

1955 Lewis Road

The Clinical Center, Bethesda, Md.

March

1955

1955

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June 15, 1955

June 15, 1955

U. S. A.

Director of Hospital

None

None (present)

James Brown

James Brown

The Clinical Center, Bethesda, Md., Maryland

None

None

None

Internal-External Hospital with National

Internal-External Hospital with National

National Center, Internal and

James Brown

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February 15, 1955

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The Clinical Center

National Institute of Health

Bethesda, Md., Maryland

1955

U. S. A.

1955

3558

CERTIFICATE OF DEATH

Reg. Dist. No. 215

03460

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Mont.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				d. STREET ADDRESS 301 Park Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Richard Middle Rollie Last FRENCH				4. DATE OF DEATH Month March Day 7 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-6-60	
9. AGE (In years last birthday) 24		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Donald French				14. MOTHER'S MAIDEN NAME Betty Ann WINNING			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Address Official Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 Atelectasis neonatorum DUE TO (b) 24 hrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Prematurity (1 month by dates)							INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 March , 19 60 to 7 March , 19 60 , that I last saw the deceased alive on 7 March , 19 60 , and that death occurred at 4:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md. DATE SIGNED							
ACTUAL SIGNATURE Howard A. Pearson M.D.				U.S. Naval Hospital, Bethesda Md.			
PHYSICIAN'S NAME (Type) H.A. PEARSON LT MC USN				U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-11-60		22c. NAME OF CEMETERY OR CREMATORY Park Lawn		22d. LOCATION (City, town, or county) (State) Rockville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler ADDRESS Tyson Wheeler E. Montgomery Ave. Rockville, Md.				24a. REC'D BY REGISTRAR MAR 11 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hanks	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051293XV4

CERTIFICATE OF DEATH

Name of Deceased: Donald Thomas
 Date of Death: March 7, 1968
 Place of Death: U.S. Naval Hospital, Bethesda, Md.
 Age: 3-6-60
 Sex: Male
 Race: White
 Marital Status: None
 Occupation: None
 Cause of Death: None
 Signature: None
 Date: None
 Place: None

U.S. Naval Hospital, Bethesda, Md.
 U.S. Naval Hospital, Bethesda, Md.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03461

Reg. Dist. No.

FOR STATE HEALTH DEPT.

Items 18&21 Film 259 3-51-60
Item 7 Film G260 4-11-60 1WK

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>	
c. LENGTH OF STAY IN 1b <u>3 months</u>		d. STREET ADDRESS <u>8012 Flower Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8012 Flower Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Paul William FRY</u> First <u>Also known as FREY</u> Last <u>Stacy</u>		4. DATE OF DEATH Month <u>Mar</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-28-1916</u>
9. AGE (In years last birthday) <u>43</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer - Fabrication plant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OHIO</u>	
11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u># 2 WW</u>		16. SOCIAL SECURITY NO. <u>269-18-3680</u>	
17. INFORMANT <u>Fry</u> Address <u>734 Longfellow St., N.W. Washington, D.C.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary atelectasis</u> <u>353.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>post epileptic seizure - natural cause</u> DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in bed</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/14/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinsler</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 must be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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3559

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Colorado b. COUNTY Walsenburg			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Box 142			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Joseph Middle Edward Last Garcia		4. DATE OF DEATH		Month March Day 2 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 25, 1946		9. AGE (In years lost birthday) 13 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Colorado		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Silbino Garcia				14. MOTHER'S MAIDEN NAME Elvira Martinez			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metabolic acidosis due to unknown cause 788.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Acute lymphocytic leukemia with central nervous system involvement							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 25, 19 60 , to March 2, 19 60 , that I last saw the deceased alive on March 2, 19 60 , and that death occurred at 7:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Lawrence A. Gaydos				ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 3/2/60	
PHYSICIAN'S NAME (Type) Lawrence A. Gaydos, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 3/3/60		22c. NAME OF CEMETERY OR CREMATORY --		22d. LOCATION (City, town, or county) (State) Walsenburg, Colorado	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. 2901 14th St., N.W. Wash. D.C.				24a. REC'D BY REGISTRAR MAR 4 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Colorado

Alamogordo

6 days

10 heads

The clinical history, between 1, 1914, to 1915

Alamogordo

Alamogordo

Alamogordo

Alamogordo, 1915

Alamogordo

Alamogordo

Alamogordo

Alamogordo

Alamogordo

The Medical Record

The Clinical History, between 1, 1914, to 1915

Metabolic disease due to unknown cause

Acute lymphocytic leukemia with cerebral metastasis

The Medical Record
National Association of Physicians
Alamogordo, 1915

Alamogordo, 1915

Alamogordo, 1915

Alamogordo, 1915

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3560

CERTIFICATE OF DEATH

03463

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>12 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edna D. Gary</u>				4. DATE OF DEATH Month Day Year <u>3/30/60</u> <u>19</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/17/79</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Wash. D. C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Dyre</u>				14. MOTHER'S MAIDEN NAME <u>Millicent Parker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>579-20-6483</u>			
17. INFORMANT <u>Daughter Winifred N. Gary same as #2</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Occlusion</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> 10 yrs + DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mitral stenosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12/30/58</u> , 19 <u>58</u> , to <u>March 30 1960</u> , that I last saw the deceased alive on <u>March 29, 1960</u> , and that death occurred at <u>6</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10511 Su mm # Ave</u> DATE SIGNED <u>3/30/60</u> ACTUAL SIGNATURE <u>George Sharpe</u> M.D. <u>Kensington Md</u> PHYSICIAN'S NAME (Type) <u>George Sharpe</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>4/2/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Hines Co.</u>				ADDRESS <u>2901 44th Ave NW</u>			
24a. REC'D BY REGISTRAR <u>APR 1 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CENTRIFUGAL OF CREAM

3210

3/20/40

50

8/10/40

10/1/40

11/1/40

100-20-4055 (100-20-4055) with 100-20-4055

100

100-20-4055 (100-20-4055) with 100-20-4055

100-20-4055 (100-20-4055) with 100-20-4055

100-20-4055 (100-20-4055) with 100-20-4055

100-20-4055 (100-20-4055) with 100-20-4055

100-20-4055 (100-20-4055) with 100-20-4055

03464

Reg. Dist. No.

24 hours after death. Page 4

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it will be returned by the funeral director to the registrar for use as the burial-transit permit. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/5B

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 222 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Clifton c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clifton d. STREET ADDRESS 38 Mayflower Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Angela Middle Catherine Last Gottlieb				4. DATE OF DEATH Month March Day 7 Year 1960					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 2, 1890		9. AGE (In years lost birthday) 69 yrs. IF UNDER 1 YEAR: Months 69 Days 69 Hours 69 Min. 69	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Joseph Bunino				14. MOTHER'S MAIDEN NAME Ursula Magenetto					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thyroid Carcinoma, Metastatic to Lungs DUE TO 194X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 194X DUE TO (c) 194X INTERVAL BETWEEN ONSET AND DEATH 15 years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus, Purulent Tracheobronchitis 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 29 , 19 59 , to March 7 , 19 60 , that I last saw the deceased alive on March 7 , 19 60 , and that death occurred at 12:10P , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3-7-60 ACTUAL SIGNATURE John W. Singleton M.D. M.D. The Clinical Center PHYSICIAN'S NAME (Type) JOHN W. SINGLETON, M.D. National Institutes of Health Bethesda 14, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-trans.		22b. DATE THEREOF 3/8/60		22c. NAME OF CEMETERY OR CREMATORY Calvary		22d. LOCATION (City, town, or county) (State) Patterson New Jersey			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE MAR 10 '60		24b. REGISTRAR'S SIGNATURE Arthur E. K...			

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

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FOR STATE
HEALTH DEPT.

M

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MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 16 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.										2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Georgia b. COUNTY Atlanta c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1503 Moury Avenue, S. E. d. STREET ADDRESS 47X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) Bobby First (None) Middle Grant Last					4. DATE OF DEATH March Month 1 Day 1960 Year																			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 26, 1955		9. AGE (In years last birthday) 4 yrs.		IF UNDER 1 YEAR Months Days 4 Months 1 Days		IF UNDER 24 HRS. Hours Min. 1 Hours 19 Min.												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child					10b. KIND OF BUSINESS OR INDUSTRY None					11. BIRTHPLACE (State or foreign country) Georgia					12. CITIZEN OF WHAT COUNTRY? U. S. A.									
13. FATHER'S NAME Robert Grant					14. MOTHER'S MAIDEN NAME Emma Cooper																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No					16. SOCIAL SECURITY NO. None					17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest due to nitrous oxide anesthesia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ventricular septal defect and aortic insufficiency DUE TO (c) Congenital heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Life										INTERVAL BETWEEN ONSET AND DEATH Life														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																								
ACTUAL SIGNATURE Frank J. Broschart										M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>										DATE SIGNED 3-1-60				
EXAMINER'S NAME (Type) Frank J. Broschart										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										Address (Street, city, town, or county)				
22a. BURIAL, CREMATION, REMOVAL (Specify) 3-3-60										22b. DATE THEREOF					22c. NAME OF CEMETERY OR CREMATORY Travis's Funeral Home, Inc. 389 R.D. W. N.W.					22d. LOCATION (City, town, or country) (State) Atlanta Georgia				
23. FUNERAL DIRECTOR Travis's Funeral Home, Inc. 389 R.D. W. N.W.										ADDRESS DC.					24a. REC'D BY REGISTRAR MAR 3 '60					24b. REGISTRAR'S SIGNATURE Arthur L. Kray				

100-111111
FBI - NEW YORK

NY 100-111111

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RECEIVED
FBI - NEW YORK
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FBI - NEW YORK

Frank J. Thompson

[Handwritten signature]

MEDICAL EXAMINER CERTIFICATE OF DEATH

NAME: [illegible] SEX: [illegible] AGE: [illegible]
RACE: [illegible] BIRTH: [illegible]

DECEASED AT: [illegible] THEATRE: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

DECEASED AT: [illegible] THEATRE: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

DECEASED AT: [illegible] THEATRE: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

DECEASED AT: [illegible] THEATRE: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

DECEASED AT: [illegible] THEATRE: [illegible]

CAUSE OF DEATH: [illegible]

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

2051306XV5

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3563
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03466

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 9602 Wadsworth Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Ann Last GRANT		4. DATE OF DEATH Month March Day 26 Year 19 60					
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-22-60	9. AGE (In years lost birthday) yrs. 4	IF UNDER 1 YEAR Months 4 Days 4 Hours 4 Min. 4		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - -		11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME Robert GRANT		14. MOTHER'S MAIDEN NAME Ann Yvonne BRIETBACH					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia and meningitis 768.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) in newborn organism DUE TO (c) unknown at present				INTERVAL BETWEEN ONSET AND DEATH 24 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mongolism				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Washington		20g. (County) D. C.		20h. (State) D. C.			
21. I certify that (I) physician attended the deceased from March 22 19 60 , to March 26 19 60 , that (I) last saw the deceased alive on March 26 19 60 , and that death occurred at 1025A M, from the causes and on the date stated above.							
22a. SIGNATURE G. B. Avery		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-26-60			
22c. PHYSICIAN'S NAME (Type) G. B. AVERY, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-29-60		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet			
23d. LOCATION (City, town, or county) Washington		23e. (State) D. C.		23f. (Country) D. C.			
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey		ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR DATE MAR 30 '60			
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus							

Results

$$(1, 0, 0) \rightarrow (0, 0, 0)$$

RAY FORD LEVER 8 0

TABLE 1

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TABLE 1. Continued

BOARD OF DIRECTORS

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11-25124-10000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-14
15M 1-59

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1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3564
CERTIFICATE OF DEATH
03467

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 3 hrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington 47X-3 d. STREET ADDRESS 5318 Belt Road, N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last Alvin Ray GREER				4. DATE OF DEATH Month Day Year March 22 1960					
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-22-60		9. AGE (In years lost birthday) yrs. Months Days Hours Mins IF UNDER 1 YEAR 3 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wilburn H. GREER				14. MOTHER'S MAIDEN NAME Audrey Louise					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Hospital Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Neonatal Atelelectasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)								INTERVAL BETWEEN ONSET AND DEATH	
21. I certify that (I) (the hospital) attended the deceased from March 22, 1960, to March 22, 1960 that (I) (we) last saw the deceased alive on March 22, 1960, and that death occurred at 7:50 P.M. from the causes and on the date stated above.									
22a. SIGNATURE F. W. GRELLO				22b. DATE 3-23-60		22c. PHYSICIAN'S NAME (Type) F. W. GRELLO, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-24-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey Funeral Home, Bethesda, Md.				25a. REGISTRY SYSTEM DATE MAR 28 60		25b. REGISTRAR'S SIGNATURE C. S. Threlk			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

3565

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03468

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5415 Bradley Blvd.		d. STREET ADDRESS 9918 Juliard Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARGARET Middle S. Last GREGORY		4. DATE OF DEATH Month Mar. Day 9, Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 16, 1906
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 3 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY West Virginia	
11. BIRTHPLACE (State or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Loman S. Stalnaker		14. MOTHER'S MAIDEN NAME Alice Shahan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Yes-Unknown	
17. INFORMANT Husband		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Congestive heart failure DUE TO (c) Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 15 min 1 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Mar. 9, 1960		20d. INJURY OCCURRED While at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 15, 1960 to Mar 9, 1960 that (I) (we) last saw the deceased alive on March 9, 1960 , and that death occurred at 4 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE Robert G. Brewer		22b. DATE SIGNED 3/10/60	
22c. PHYSICIAN'S NAME (Type) ROBERT G. BREWER M.D.		22d. ADDRESS 8218 WISCONSIN AVE BETHESDA MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/14/60	
23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town, or county) (State) Parsons, West Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
25a. REC'D BY REGISTRAR MAR 11 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

03108

COLLIGATE OF 1911

361

OLD GOREY

Harvard

Monte Carlo

Brady

Brady

Brady

Brady

MARGARET

MARGARET

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3566
03469
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Hammond</u> Last <u>Grimes</u>		4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/23/02</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Lumber</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Basil Grimes</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ida Tasker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-01-5834</u>	
17. INFORMANT <u>HA</u>		Address <u>Hospital Records, Olney, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Myeloma</u> <u>203X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 29, 1959</u> to <u>Mar 29, 1960</u> that (I) (we) last saw the deceased alive on <u>Mar 29, 1960</u> and that death occurred at <u>2:10 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Jack Schumacher</u>		22b. DATE SIGNED <u>APR 4 '60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Jack Schumacher</u>		22d. ADDRESS <u>Gaithersburg Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 1, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Laytonville Meth.</u>		23d. LOCATION (City, town, or county) (State) <u>Laytonville Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u>		25a. REC'D BY REGISTRAR <u>APR 4 '60</u>	
ADDRESS <u>Laytonville, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

103618

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS AND STATISTICS
CERTIFICATE OF DEATH

3500

NAME OF DECEASED
AGE
SEX
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
OCCUPATION
EDUCATION
RELIGION
MARRIAGE
SINGLE
MARRIED
WIDOWED
DIVORCED
REMARKS

Multiple Myeloma

DATE OF INTERVIEW
INTERVIEWER
SIGNATURE OF DECEASED
SIGNATURE OF WITNESS
SIGNATURE OF PHYSICIAN
SIGNATURE OF REGISTRAR
OFFICIAL SEAL

1. ~~X~~
FOR-STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Pages 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3513 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03470

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN lb <u>life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville</u>		d. STREET ADDRESS <u>Travilah Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Travilah Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Robert Chas. Angelo Grimes</u>				4. DATE OF DEATH Month <u>Mar</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>6-5-1898</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>farmer</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>							
13. FATHER'S NAME <u>Angelo Grimes</u>				14. MOTHER'S MAIDEN NAME <u>Mary Carter</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes-Unkn.</u>		17. INFORMANT <u>Arthur Grimes (brother)</u>		Address <u>Stn 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cerebral occlusion</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> (b) <u> </u> (c) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in yard near home</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				<u>3-25-60</u>			
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/28/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Church Cem</u>		22d. LOCATION (City, town, or country) (State) <u>Darnestown, Maryland</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 30 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MEDICAL CERTIFICATION

2

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

3438

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03471

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 18 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 150 Bonifant Road			d. STREET ADDRESS 150 Bonifant Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LOTTIE Middle LEE Last GRUSSNER			4. DATE OF DEATH Month MARCH Day 12 Year 19 60		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH APRIL 27, 1897		9. AGE (In years last birthday) 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY THE HECHT CO.		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES E. BARROW			
14. MOTHER'S MAIDEN NAME MATTIE W. CLEMENT		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 579-40-3239		17. INFORMANT Address SILVER SPRING, MD. MRS. KATHERINE E. LUKENS, 150 BONIFANT RD.,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH Found dead in bed yrs.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/12/60	
EXAMINER'S NAME (Type) FRANK J. BROSCART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL		22b. DATE THEREOF 3/15/60		22c. NAME OF CEMETERY OR CREMATORY FOREST LAWN CEMETERY	
22d. LOCATION (City, town, or county) (State) RICHMOND, VIRGINIA		24a. REC'D BY REGISTRAR DATE MAR 15 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PIMPHREY, INC.		ADDRESS SILVER SPRING, MD.			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03472

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wheaton Nursing Home</u>		d. STREET ADDRESS <u>16 Eastmore Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Josephine Agnes Haas</u>		4. DATE OF DEATH Month Day Year <u>march 18 1960</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 1, 1876</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>St. Paul, Minn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Zahn</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>Mrs. Kathryn Diekel- 6 Eastmore Drive, S. Spring</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Epidermoid carcinoma of bladder</u> <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Hilbert S. Sabin</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Hilbert S. Sabin</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		22b. DATE THEREOF <u>3/19/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St. Paul, Minnesota</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 21 '60</u>	
ADDRESS <u>Wash, DC</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hines</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G260 4/11/60 1b

3567

CERTIFICATE OF DEATH

Reg. Dist. No.

03473

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 25 Hrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 58 Chevy Chase d. STREET ADDRESS 111 Grafton St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle R. Last Hardesty		4. DATE OF DEATH Month March Day 29 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 28, 1880
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR: Months 1 Days 12 Hours 12 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Henry De Groat Hardesty		14. MOTHER'S MAIDEN NAME Frances Dix	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Army	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Hypertension DUE TO (b) 2 yrs. DUE TO (c) 17 days		18. INTERVAL BETWEEN ONSET AND DEATH 17 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month Mar Day 29 Year 1960 Hour 8 a. m. 19 p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Berryville (County) Virginia (State) Virginia	
21. I certify that I attended the deceased from Mar 28, 1960 to Mar 29, 1960 , that I last saw the deceased alive on Mar 29, 1960 , and that death occurred at 2:20 p. m. from the causes and on the date stated above.			
ACTUAL SIGNATURE A. H. Richwine M.D.		ADDRESS (Street, city or town, State) 5522 Chestnut Ave. 29 Mar. 1960	
PHYSICIAN'S NAME (Type) A. H. Richwine		DATE SIGNED 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/1/60	
22c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery		22d. LOCATION (City, town, or county) Berryville, Virginia (State) Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Enders		24a. REC'D BY REGISTRAR APR 4 '60	
ADDRESS Berryville, Va.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
VS A15 (4)
ISM 9/58

STATE OF TEXAS
COUNTY OF DALLAS

NOTARY PUBLIC

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My Comm. Expires

My Comm. Expires

My Comm. Expires

My Comm. Expires

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My Comm. Expires

SALARY STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 6, Film G250 3/23/60 1b

3472

CERTIFICATE OF DEATH

Reg. Dist. No.

03474

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARDELPHI	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSPITAL		d. STREET ADDRESS 2212 PHELPS RD.	
3. NAME OF DECEASED (Type or print) First ALEXANDER Middle STEPHEN Last HARDY		4. DATE OF DEATH Month 3 Day 18 Year 1960	
5. SEX MALE	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-11-59
9. AGE (In years last birthday) 9 MONTHS 9		10. IF UNDER 1 YEAR Months 9 Days - Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME STEPHEN C. HARDY		14. MOTHER'S MAIDEN NAME SUSANNE ROBINSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. none	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.5 DUE TO Respiratory infection Complicated heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 12 hr
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3/17/60 , 19 60 , to 3/18 , 19 60 that I last saw the deceased alive on 19 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Marvin Mones		M.D.	
PHYSICIAN'S NAME (Type) MARVIN MONES		Silver Spring Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL	22b. DATE THEREOF 3/20/60	22c. NAME OF CEMETERY OR CREMATORY Back Creek Associate Reform Presbyterian Church Cemetery	22d. LOCATION (City, town, or county) (State) CHARLOTTE, N.C.
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.		24a. REC'D BY REGISTRAR Mar 21 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Hume

Page 4

24 hours after death. The law requires that the death certificate be executed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

3568

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 17, MARYLAND

CERTIFICATE OF DEATH

03475

Item 2 C & D, Film 0260 4/12/60 iwk

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Potomac		c. LENGTH OF STAY IN 1b 2½ Years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Potomac Burtonsville, Md.-with neice		d. STREET ADDRESS & her husband both now deceased in the past 2 yrs. Ropine Nursing Home	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ropine Nursing Home		e. IS RESIDENCE A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) JAMES FRANKLIN HAYWARD		4. DATE OF DEATH Month March Day 27 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16, 1895
9. AGE (In years lost birthday) 64 yrs.		IF UNDER 1 YEAR Months 6 Days 11 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Virginia /		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME William H. Hayward		14. MOTHER'S MAIDEN NAME Emma Hampton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. James H. Hayward	
17. INFORMANT Son		5506 High Ridge St. Arbutus, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Vascular Disease DUE TO (c) Cerebral Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1959 to Mar. 24, 1960 that (I) had last saw the deceased alive on Mar. 24, 1960 , and that death occurred at 3P. M. from the causes and on the date stated above.			
22a. SIGNATURE William H. Killay		22b. DATE SIGNED 3-28-60	
22c. PHYSICIAN'S NAME (Type) WILLIAM H. KILLAY		22d. ADDRESS 9902 Counselman Rd., Potomac, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 3-28-60		23b. DATE THEREOF 3-28-60	
23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery		23d. LOCATION (City, town, or county) (State) Richmond, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR Bethesda, Md.	
25b. REGISTRAR'S SIGNATURE Curtis S. Hanna		DATE APR 4 '60	

DECLARATION OF DEATH

0317

NAME: JAMES EARL RAY, JR.
DATE OF BIRTH: 10-10-1928
PLACE OF BIRTH: MOBILE, ALABAMA
RESIDENCE: 1000 1/2 AVENUE, NASHVILLE, TENNESSEE
OCCUPATION: MEMBER OF CONGRESS

DECLARED BY: JAMES E. RAY, JR.
RELATIONSHIP: SON
SIGNATURE: [Signature]
WITNESSES: [Signatures]

DATE: MARCH 28, 1968
PLACE: MEMPHIS, TENNESSEE
DECLARED BY: JAMES E. RAY, JR.
RELATIONSHIP: SON
SIGNATURE: [Signature]
WITNESSES: [Signatures]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

3369
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03476

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 35 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital						d. STREET ADDRESS 4505 Chase Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Albert		Middle Virgil		Last HEADLEY		4. DATE OF DEATH Month March		Day 23		Year 19 60	
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-20-02		9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) West Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Albert N. HEADLEY						14. MOTHER'S MAIDEN NAME Bertha STARR					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214-28-4289		17. INFORMANT Hospital Records							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma, Brain DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 177X Adeno Carcinoma, Prostate (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 weeks									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) this hospital attended the deceased from February 17, 19 60 to March 23, 19 60 , that (I) was last saw the deceased alive on March 23, 1960 , and that death occurred at 10:35 AM from the causes and on the date stated above.											
22a. SIGNATURE H. S. IRONS, LT, MC, USN				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 3-23-60			
22c. PHYSICIAN'S NAME (Type) H. S. IRONS, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-28-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION (City, town, or county) (State) Arlington Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey				ADDRESS R. A. Humphrey Funeral Home, Bethesda, Md.				25a. REC'D BY REGISTRAR DATE MAR 28 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

3570

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>2 1/2 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				d. STREET ADDRESS <u>6004 MILO DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hayward</u> Middle <u>Roy</u> Last <u>Henderson</u>				4. DATE OF DEATH Month <u>3</u> Day <u>6</u> Year <u>1960</u>			
5. SEX <u>m.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 25 - 1904</u>		9. AGE (In years lost birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>11</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HEAVY EQUIPMENT SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>London County VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Henry Henderson</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Martha Ellen Franks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-01-4557</u>		INFORMANT <u>Rose Lila Shinghuff</u> Address <u>6004 MILO DR. WOODACRES MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>cerebrovascular accident - ? hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>9 hours</u> (b) <u>Hypertensive Cardiovascular disease</u> <u>6 years</u> (c) <u>Cerebral vascular insufficiency</u> <u>1 1/2 years</u> Lying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>LACERATION OF CHIN IN FALL</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>neither</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient fell forward in living room, striking chin on furniture</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>2</u> p. m. <u>3-5</u> 19 <u>60</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOME</u>		20f. (City or town) (County) (State) <u>HOME ADDRESS</u>
21. I certify that I attended the deceased from <u>3-6</u> , 19 <u>60</u> , to <u>3-6</u> , 19 <u>60</u> that I last saw the deceased alive on <u>3-6</u> , 19 <u>60</u> , and that death occurred at <u>5:50 AM</u> , from the causes and on the date stated above. <u>Patient under care of Dr. William Howell and Arthur H. ...</u> ADDRESS (Street, city or town, state) <u>Washington Clinic</u> DATE SIGNED <u>3-6-60</u> ACTUAL SIGNATURE <u>Edward W. Youngblood, M.D.</u> CLEARED & MEDICAL EXAMINER BY <u>DR. YOUNGBLOOD</u> PHYSICIAN'S NAME (Type) <u>EDWARD W. YOUNGBLOOD, MD</u> <u>Washington 15, D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>3-8-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FAIRVIEW CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WARRENTON, N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Garbison</u> ADDRESS <u>1756 Pa. Ave. NW. Wash. D.C.</u>				24a. REC'D BY REGISTRAR <u>DATE MAR 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. ...</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

3571

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural) c. LENGTH OF STAY IN 1b 42 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Bermuda b. COUNTY U.S. Naval Station 15X-1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle John Last HENDERSON			4. DATE OF DEATH Month March Day 16 Year 19 60				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-9-57		9. AGE (In years lost birthday) 2 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Massachusetts			
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME James (n) Henderson				
14. MOTHER'S MAIDEN NAME Deloris FERRI			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				
16. SOCIAL SECURITY NO. None			INFORMANT (Father) James Henderson Address Same as #2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.5 DUE TO Congenital heart disease (atrio-ventricular canal, complete) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 yrs DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2					INTERVAL BETWEEN ONSET AND DEATH 2 yrs		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. Naval Hospital, Bethesda, Md.			
20f. (City or town) New London, Conn.		(County)		(State)			
21. I certify that I attended the deceased from 3 February , 19 60 , to 16 March , 19 60 , that I last saw the deceased alive on 16 March , 19 60 , and that death occurred at 9:50 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED James E. Mc Clenathan							
ACTUAL SIGNATURE James E. Mc Clenathan			PHYSICIAN'S NAME (Type) J.E. MC CLENATHAN CDR MC USN				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			22b. DATE THEREOF 3-18-60		22c. NAME OF CEMETERY OR CREMATORY St. Mary's		
22d. LOCATION (City, town, or county) New London, Conn.			(State)				
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey			ADDRESS 1557 Wisconsin Ave. Bethesda, Md.		24a. REC'D BY REGISTRAR MAR 21 '60		
24b. REGISTRAR'S SIGNATURE William S. Fraser							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3

U.S. Naval Hospital

12 days

(Total)

U.S. Naval Hospital, Baltimore, Md.

U.S. Naval Hospital, Baltimore, Md.

12 days

12 days

12 days

U.S. Naval Hospital

12 days

12 days

U.S. Naval Hospital

12 days

12 days

U.S. Naval Hospital

U.S. Naval Hospital

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U.S. Naval Hospital

U.S. Naval Hospital

U.S. Naval Hospital

U.S. Naval Hospital

U.S. Naval Hospital

3572

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 8 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia		b. COUNTY 83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS Rural Route #2 Box 62				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Andrew Dean HENNESSEE		4. DATE OF DEATH Month Day Year March 9 1960		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1-7-60		9. AGE (In years lost birthday) yrs. 2		IF UNDER 1 YEAR Months Days Hours Min. 2 2		IF UNDER 24 HRS. 2			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME George H. Hennessee				14. MOTHER'S MAIDEN NAME Louis ACKERMAN					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT (Father) George H. Hennessee		Address Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) sudden cardiovascular collapse 756.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) chronic starvation and depletion DUE TO (c) congenital stenosis, jejunum with " " 2 DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) recurrent intestinal obstruction								INTERVAL BETWEEN ONSET AND DEATH 5 min 8 wks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Orange		(County) (State)	
21. I certify that I attended the deceased from 1 March , 19 60 , to 9 March , 19 60 , that I last saw the deceased alive on 9 March , 19 60 , and that death occurred at 8:10A M, from the causes and on the date stated above.									
ACTUAL SIGNATURE G.B. Avery				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda Md.					
PHYSICIAN'S NAME (Type) G.B. AVERY LT MC USN				DATE SIGNED 3-9-60					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-12-60		22c. NAME OF CEMETERY OR CREMATORY Orange Cemetery		22d. LOCATION (City, town, or county) (State) Orange Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR MAR 11 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Now 4/1/60

9 VVVVVVVV XVV

CERTIFICATE OF DEATH

1. Name of deceased: *Robert (L.)*
2. Date of death: *8 days*
3. Place of death: *U.S. Naval Hospital, Bethesda, Md.*
4. Cause of death: *Heart failure*
5. Date of birth: *1-1-33*
6. Place of birth: *Virginia*
7. Sex: *Male*
8. Race: *White*
9. Occupation: *None*
10. Service: *None*
11. Signature of physician: *(Signature)*
12. Signature of registrar: *(Signature)*

Robert (L.) was born on 1-1-33 at [illegible] Virginia. He was a [illegible] and was [illegible] at the U.S. Naval Hospital, Bethesda, Md. on 8 days. The cause of death was heart failure. The death was certified by [illegible] and [illegible].

13. Date of death: *8 days*
14. Place of death: *U.S. Naval Hospital, Bethesda, Md.*
15. Cause of death: *Heart failure*
16. Date of birth: *1-1-33*
17. Place of birth: *Virginia*
18. Sex: *Male*
19. Race: *White*
20. Occupation: *None*
21. Service: *None*
22. Signature of physician: *(Signature)*
23. Signature of registrar: *(Signature)*

3509

CERTIFICATE OF DEATH

Reg. Dist. No.

03480

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the medical records retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>090 Carroll Hall Sanitarium</u>		d. STREET ADDRESS <u>3380 Stuyvesant Pl. NW</u>	
3. NAME OF DECEASED (Type or print) First <u>GENEVIEVE</u> Middle <u>M.</u> Last <u>HENNESSEY</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 31, 1873</u>
9. AGE (In years lost birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>MD</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Simon P. Tennyson</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Cecelia Russell</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		INFORMANT Address <u>3380 Stuyvesant Pl. NW</u> <u>Mrs. Joseph T. Corbly</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X HYPERTENSIVE HEART DISEASE</u> DUE TO (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>ESSENTIAL HYPERTENSION</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov. 19, 1958</u> to <u>March 8, 1960</u> that I last saw the deceased alive on <u>March 8, 1960</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Heursem Rucker</u> M.D.		ADDRESS (Street, city or town, state) <u>5206 Norway Dr.</u> DATE SIGNED <u>3/8/60</u>	
PHYSICIAN'S NAME (Type) <u>Chery Chase, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>3/11/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Wash. DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chery Chase Funeral Home Wash. DC.</u>		24a. REC'D BY REGISTRAR <u>5103 Wilson</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>

10-10-10

STATE OF TEXAS
COUNTY OF DALLAS

10-10-10

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of said County, at Dallas, Texas, this 10th day of October, 1910.

County Clerk

MEDICAL CERTIFICATION

VS A15 (4)
ISM 9/SB

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3473

CERTIFICATE OF DEATH

03482

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. LENGTH OF STAY IN 1b 12 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 304 Philadelphia Ave.				d. STREET ADDRESS 304 Philadelphia Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First SOPHIA Middle ELEANOR Last HOBBS				4. DATE OF DEATH Month MARCH Day 4 Year 19 60			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/10/86	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Highland, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILBUR FISKE CISSEL				14. MOTHER'S MAIDEN NAME CLARA E. BROWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Robert A. Phillips, 825 Violet Place			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE UTERUS DUE TO 174X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARICULAR FIBRILLATION		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from MAR. 19 59 , to MAR. 4 , 19 60 , that I last saw the deceased alive on 3 MAR. 19 60 , and that death occurred at 12:30 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE L.B. Snow		ADDRESS (Street, city or town, state) 7950 N.H. AVE. LANGLEY PARK MD.		DATE SIGNED 3/4/60			
PHYSICIAN'S NAME (Type) L. B. SNOW							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3/8/60	22c. NAME OF CEMETERY OR CREMATORY MOUNT VIEW CEMETERY		22d. LOCATION (City, town, or county) (State) HOWARD COUNTY, MARYLAND			
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Giska		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE MAR 7 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Huns		

3574

CERTIFICATE OF DEATH

Reg. Dist. No.

03483

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattstown</u>	c. LENGTH OF STAY IN 1b <u>28 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>L</u>		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Minerva</u> First <u>Cragin</u> Middle <u>Hornie</u> Last		4. DATE OF DEATH <u>March</u> Month <u>22</u> Day <u>1960</u> Year	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Dec-6-1866</u>
9. AGE (In years lost birthday) <u>93</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>16</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house-keeping</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Phillip C. Hudrow</u>	
14. MOTHER'S MAIDEN NAME <u>Achsa Ann Hudrow</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Edmah E. Washburn, Hyattstown, Md</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute heart failure</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pleuro-pneumonia</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u> <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>L</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify, that I attended the deceased from <u>3-18-1960</u> , to <u>3-22-1960</u> , that I last saw the deceased alive on <u>March-22-1960</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William C. Miller</u> M.D.		ADDRESS (Street, city or town, state) <u>7-Brooks avenue</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>WILLIAM C. MILLER</u>		<u>Gaithersburg, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-25-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Christian Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hyattstown, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. L. Burdette, Hyattstown, Maryland</u> ADDRESS		24a. REC'D BY REGISTRAR <u>MAR 24 '60</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Gailus S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3440

CERTIFICATE OF DEATH

Reg. Dist. No.

03484

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MONTGOMERY</u> b. COUNTY <u>MARYLAND</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVERSPRING</u>		c. LENGTH OF STAY IN 1b <u>29 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVERSPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1910 Luzerne Avenue</u>				d. STREET ADDRESS <u>1910 LUZERNE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>HUNTER</u> Last <u>HUNTER</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 9 1878</u>		9. AGE (In years last birthday) yrs. <u>81</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL MULLOY</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Adams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Regina Hunter</u> Address <u>1910 LUZERNE AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month _____ Day _____ Year <u>19</u> Hour _____ a. m. _____ p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>55</u> , to <u>MARCH 3</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>MARCH 1</u> , 19 <u>60</u> , and that death occurred at <u>11:53 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>SARAH E. GLOVER</u>				M.D. <u>10128 CEDAR LANE</u> <u>RENSING TOW, MD</u>		DATE SIGNED <u>3-3-60</u>	
PHYSICIAN'S NAME (Type) <u>SARAH E. GLOVER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/7/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>		22d. LOCATION (City, town, or county) _____ (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc., Silver Spring, MD.</u> <u>Raymond A. Ziska</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3474 CERTIFICATE OF DEATH

Reg. Dist. No.

03485

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

c. LENGTH OF STAY IN 1b

1 day

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

17 Takoma Park

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Washington San. & Hospital

d. STREET ADDRESS

18200 Flower Ave

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)

First

Lora

Middle

Adell

Last

Hurd

4. DATE OF DEATH

Month

Mar.

Day

24

Year

1960

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

B. DATE OF BIRTH

8-27-77

9. AGE (In years last birthday)

82 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired teacher

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Winifield S. Turner

14. MOTHER'S MAIDEN NAME

Elizabeth Welch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO. (If yes, give war or dates of service)

INFORMANT

Address

W.S.H. Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

592x

DUE TO

Intestinal Obstruction

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

Uremic State - Chr Nephritis.

(c)

INTERVAL BETWEEN ONSET AND DEATH

5 days

?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.

19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from March 24, 1960 to March 24, 1960 that I last saw the deceased alive on March 24, 1960 and that death occurred at 2:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE

Robert A. Hare

ADDRESS (Street, city or town, state)

7600 Carroll Ave Takoma Park, M.D.

DATE SIGNED

3/24/60

PHYSICIAN'S NAME (Type)

Robert A. Hare

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

March 29, 1960

22c. NAME OF CEMETERY OR CREMATORY

East Springfield Cemetery

22d. LOCATION (City, town, or county)

East Springfield, Pa

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Arthur Walters 254 Carroll St. N.W.

24a. REC'D BY REGISTRAR

MAR 28 '60

DATE

24b. REGISTRAR'S SIGNATURE

Arthur S. Hana

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3575

CERTIFICATE OF DEATH

Reg. Dist. No.

03486

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Connecticut b. COUNTY Fairfield ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 26 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Barbara Middle Ann Last Ivan				4. DATE OF DEATH Month March Day 18 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 24, 1892	
9. AGE (In years lost birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Kurovics				14. MOTHER'S MAIDEN NAME Rosalie Vereb			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Renal Disease with Uremia and Acidosis DUE TO 199.2 Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Metastatic Carcinoid DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Months Months							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 21 1960 to March 18 1960 , that I last saw the deceased alive on March 18 1960 , and that death occurred at 12:10pm , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3-18-60							
ACTUAL SIGNATURE Joseph C. Greenfield Jr. M.D.				PHYSICIAN'S NAME (Type) JOSEPH C. GREENFIELD, JR., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 3-19-60				22b. DATE THEREOF 3-19-60			
22c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery				22d. LOCATION (City, town, or county) (State) Stratford, Conn.			
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY ADDRESS Bethesda, Md.				24a. REC'D BY REGISTRAR MAR 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10-11-50

3237

Connecticut Fairfield

Bridgeport 25 days

The Clinical Center, Bethesda, Md., 122 Hill View Avenue

Barbara Ann Ryan Karen

December 25, 1952

January 1953

Joseph Korovin

The Clinical Center, Bethesda, Md., Maryland

Chronic renal disease with uremia and edema

Chronic renal disease

Chronic renal disease

Chronic renal disease

Chronic renal disease

Chronic renal disease

Chronic renal disease

Chronic renal disease

Chronic renal disease

Chronic renal disease

3576

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 32 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harry Middle Edward Last Jacobs				4. DATE OF DEATH Month March Day 25 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 2, 1957	
9. AGE (In years last birthday) 3 yrs.		10. IF UNDER 1 YEAR Months 3		11. IF UNDER 24 HRS. Days 2		12. IF UNDER 24 HRS. Hours 10 Min. 35.2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Charles E. Jacobs				14. MOTHER'S MAIDEN NAME Clara Orndorff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT The Medical Record				Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro-Intestinal Hemorrhage 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Lymphocytic Leukemia DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 year							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from February 22, 1960 to March 25, 1960 , that I last saw the deceased alive on March 25, 1960 , and that death occurred at 9:50 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE L. A. Gaydos				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) LAWRENCE A. GAYDOS, M.D.				DATE SIGNED 3-24-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-26-60		22c. NAME OF CEMETERY OR CREMATORY Unknown		22d. LOCATION (City, town, or county) (State) Brunswick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. Inc.				ADDRESS 1400 Chapin St. N.W.		24a. REC'D BY REGISTRAR MAR 29 1960	
				24b. REGISTRAR'S SIGNATURE Arthur L. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

LOCAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 retained by the hospital or attending physician.
LOCAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it must be submitted to the local health officer for signature.

hours after death. Page 4

in by the funeral director,

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3577

CERTIFICATE OF DEATH

Reg. Dist. No.

03488

1. PLACE OF DEATH o. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
c. LENGTH OF STAY IN 1b 100 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 10417 Haywood Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harold Middle (None) Last Jacobstein		4. DATE OF DEATH Month March Day 23 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 26, 1925
9. AGE (In years lost birthday) 34 yrs.		IF UNDER 1 YEAR Months 34 Days 34 Hours 34 Min. 34	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10b. KIND OF BUSINESS OR INDUSTRY Government	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Benjamin A. Jacobstein		14. MOTHER'S MAIDEN NAME Fannie Weitzman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 207-12-1933	
INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Metastatic Synovioma, Lungs DUE TO 227x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Synovioma, Left Knee (b) Synovioma, Left Knee DUE TO 227x (c) Synovioma, Left Knee		INTERVAL BETWEEN ONSET AND DEATH Months Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 14, 19 59 , to March 23, 19 60 , that I last saw the deceased alive on March 23, 19 60 , and that death occurred at 3:10p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3-23-60 ACTUAL SIGNATURE Richard C. Mechanic M.D. National Institutes of Health PHYSICIAN'S NAME (Type) RICHARD C. MECHANIC, M.D. Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/25/60	
22c. NAME OF CEMETERY OR CREMATORY Springton Cemetery		22d. LOCATION (City, town, or county) (State) Springton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Amos H. Hannon ADDRESS 3831-GA Ave NW		24a. REC'D BY REGISTRAR DATE MAR 29 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hannon			

MEDICAL CERTIFICATION

Page 3 should be attached for use of the burial-transit permit. If the cause of death is not stated, the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

CERTIFICATE OF DEATH

1942

100 days

100 days

100 days

100 days

100 days

100 days

100 days

100 days

100 days

100 days

100 days

100 days

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3578

CERTIFICATE OF DEATH

03489

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Henrico ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b* 90 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Stella Middle Anna Last Janiski		4. DATE OF DEATH Month March Day 2 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 9, 1908
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months 56 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stanley Staszak		14. MOTHER'S MAIDEN NAME Anna Romanik	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unascertainable	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular hemorrhage 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic pyelonephritis, uremia DUE TO (c) Collagen disease with cryoglobulinemia		INTERVAL BETWEEN ONSET AND DEATH 56 hours 7 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary infarctions, splenic infarction, hemorrhage cystitis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 3, 1959 , to March 2, 1960 , that I lost the deceased alive on March 2, 1960 , and that death occurred at 2:05 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul J. Schwab		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Paul J. Schwab, M.D.		DATE SIGNED 2 Mar. 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 5, 1960	22c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary Cent Baltimore, Maryland	
22d. LOCATION (City, town, or county) (State) Baltimore, Maryland		22e. REC'D BY REGISTRAR Arthur S. Hume	
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran		24. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Deceased's Name: [Name]

Residence: [Address]

Age: [Age]

Sex: [Sex]

Marital Status: [Status]

Date of Birth: [Date]

Place of Birth: [Place]

Occupation: [Occupation]

Education: [Education]

Religion: [Religion]

Usual Place of Work: [Work]

Date of Death: [Date]

Time of Death: [Time]

U.S.A.

Signature: [Signature]

Witness: [Witness]

Registrar: [Registrar]

Medical Officer: [Officer]

Registrar: [Registrar]

Medical Officer: [Officer]

30 hours

Cardiovascular system

7 months

Chronic pyelonephritis, uremia

Collagen disease with cryoglobulinemia

Pulmonary infarction, splenic infarction, hemorrhagic cystitis

December 3, 1960

March 2, 1961

2 Jan. 1960

The Medical Officer

Attest: Registrar of Births

Signature: [Signature]

Signature: [Signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3475 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03490

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SANITARIUM & HOSPITAL</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 TAKOMA PARK 12, MARYLAND</u>			
f. STREET ADDRESS <u>712 GILBERT ST. Apt 1</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) (MRS.) <u>ANN</u> <u>ELIZABETH</u> <u>JATMAN</u>				4. DATE OF DEATH Month <u>MAR</u> Day <u>3rd</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-28-16</u>	
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>HAWAII, HAWAII</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME <u>Wong Chai</u>				14. MOTHER'S MAIDEN NAME <u>NOT AVAILABLE CHANG SEE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>TAKOMA PARK</u> <u>MR. ARNOLD JATMAN - 712 Gilbert St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> <u>754.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congenital heart disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>life</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>March 9, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Arthur Walters, 254 Carroll St NW 296</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Farris</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE _____		RACE _____	
DATE OF DEATH _____		TIME OF DEATH _____	
PLACE OF DEATH _____		CITY _____	
COUNTY _____		STATE _____	
OCCUPATION _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		MEDICAL HISTORY _____	
PREVIOUS ILLNESS _____		MEDICAL OPINION _____	
SIGNATURE OF EXAMINER _____		SIGNATURE OF WITNESS _____	
DATE OF SIGNATURE _____		DATE OF SIGNATURE _____	

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3579
CERTIFICATE OF DEATH

03491

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 32 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		f. STREET ADDRESS Rt 2 Box 137	
3. NAME OF DECEASED (Type or print) First Andrew Middle Herbert Last Johnson		4. DATE OF DEATH Month March Day 20 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-21-1879
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 80 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Ill.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter Johnson		14. MOTHER'S MAIDEN NAME Christine Linquist	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hazel SCHIEKE, Rt. Box #2, Box 137, Edgewater, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Lobar, Right 141.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Squamous Cell, Carcinoma of Tongue DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 4-5 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 18 February, 1960 , to 20 March, 1960 , that I last saw the deceased alive on 20 March, 1960 , and that death occurred at 225 a. m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE Vernon N. Houk M.D.		PHYSICIAN'S NAME (Type) Vernon N. HOUK, LT MC USN	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF Mar 23, 1960	
22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John TAYLOR & Sons, 147 Duke of Gloucester St. Annapolis, Md.		24a. REC'D BY REGISTRAR DATE MAR 24 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

3738

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3581
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		d. STREET ADDRESS 3244 Chestnut St., N. W.	
3. NAME OF DECEASED (Type or print) Ann First B. Middle Jones Last		4. DATE OF DEATH Month 3 Day 2 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/21/21
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Fall River, Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter F. Brow		14. MOTHER'S MAIDEN NAME Ann O'Donnell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Husband		Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral edema 190.9 DUE TO Encephalomalacia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic melanoma of the left parietal bone (c) Unknown			INTERVAL BETWEEN ONSET AND DEATH 3 Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 14 , 19 59 , to March 2 , 19 60 , that I last saw the deceased alive on March 2 , 19 60 , and that death occurred at 2 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert G. Brewer M.D.		ADDRESS (Street, city or town, state) Suburban Hospital	
PHYSICIAN'S NAME (Type) Robert Brewer, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 3/5/60	22c. NAME OF CEMETERY OR CREMATORY Conestoga Mem. Pk.	22d. LOCATION (City, town, or county) (State) Lancaster, Pa.
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee ADDRESS 3004 5th St. N.E. Wash D.C.		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

CERTIFICATE OF DEATH

3281

STATE OF MICHIGAN
COUNTY OF [illegible]
CITY OF [illegible]

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FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

3582 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring D.O.A.</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Silver Spring - B-2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>Monty Co. Gen. Hosp</u>				d. STREET ADDRESS <u>Stewart Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anthony Tyrone Jones</u>				4. DATE OF DEATH <u>Mar 27 1960</u>		5. SEX <u>Male</u>	
6. COLOR OR RACE <u>col</u>		7. MARKED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-22-59</u>		9. AGE (In years last birthday) <u>3</u> yrs. <u>5</u> months <u>5</u> days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <u>md Monty. Co.</u>		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <u>Walter Jones</u>				14. MOTHER'S MAIDEN NAME <u>Fraunce Poge</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Fraunce Jones (mother)</u> <u>Item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>475 X Asphyxia</u> DUE TO (b) <u>Upper Respiratory Infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3-27-60</u>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/30/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park.</u>		22d. LOCATION (City, town, or country) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR <u>Robert L. Sumrell</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>APR 4 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>			

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FOR MAIL
SECTION

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RECEIVED
JUN 10 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C.

3382

3382 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

[Faint, mostly illegible text from the reverse side of the document, including fields for name, date, and medical history.]

3441

CERTIFICATE OF DEATH

03494

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b Appros. 6 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2905 SHERATON ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BETRUE Middle PRICE Last JONES		4. DATE OF DEATH Month MARCH Day 8 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/3/85
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EPHRIAM PRICE		14. MOTHER'S MAIDEN NAME MARY RICHARDS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. INFORMANT Mr. H. Jones, 2905 Sheraton St., Wheaton Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia due to 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Nephrosclerosis due to DUE TO (c) Arterio Sclerosis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Arthritis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/10/58 to 3/8/60 , that I last saw the deceased alive on 3/18/60 , 19 60 , and that death occurred at 5A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10620 Georgia Ave Silver Spring, Md DATE SIGNED 3/18/60			
ACTUAL SIGNATURE John J. Curry		PHYSICIAN'S NAME (Type) JOHN J. CURRY	
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL 3/11/60	22b. DATE THEREOF 3/11/60	22c. NAME OF CEMETERY OR CREMATORY MEMORIAL SHRINE CEMETERY	22d. LOCATION (City, town, or county) (State) CENTERMORELAND, PENNSYLVANIA
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska		24a. REC'D BY REGISTRAR MAR 9 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

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VS A15 (4)
ISM 9/58

Page 4

24 hours after death.

the death certificate be executed within 24 hours after death.

the law requires that the death certificate be executed within 24 hours after death.

be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

321

[Faint, mostly illegible text and lines, likely representing a form for a Certificate of Death. The text is mirrored and difficult to decipher.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3514 CERTIFICATE OF DEATH

03495

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville, Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5501 Golf Lane</u>		d. STREET ADDRESS <u>5501 Golf Lane</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Christopher</u> First <u>Noland</u> Middle <u>Jones</u> Last		4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/1/59</u>
9. AGE (In years lost birthday) <u>11</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>15</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u></u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stephen Noland Jones</u>		14. MOTHER'S MARDEN NAME <u>Ann Crowley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mother.</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>096.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Overwhelming Virus Infection</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u></u> Day <u>19</u> Year <u></u> Hour a. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>15 March 1960</u> to <u>16 March 1960</u> , that (I) (we) last saw the deceased alive on <u>16 March 1960</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Francis J. Troendle</u>		22b. DATE SIGNED <u>17 March 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Francis J. Troendle</u>		22d. ADDRESS <u>809 VIERS MILL RD, ROCKVILLE Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/19/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 18 '60</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

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10400

THE BUREAU OF VITAL RECORDS OF THE STATE OF NEW YORK

CERTIFICATE OF DEATH

1911

10400

State of New York, County of Westchester, City of New York.
I, the undersigned, being a duly qualified Medical Officer of Health,
do hereby certify that on the 10th day of March, 1911, at New York,
New York, died _____, Male, of the age of _____ years,
cause of death _____.

Signature of Medical Officer of Health _____
Signature of Registrar _____
Signature of Coroner _____

Witness my hand and seal this _____ day of _____, 1911.
At New York, New York.

Medical Officer of Health

3442

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>8617 Piney Branch Rd</u> <u>Montgomery County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same as 1A</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>12 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Same as 1b</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>8617 Piney Branch Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marquerite F. Jordan</u>				4. DATE OF DEATH Month Day Year <u>March 4th 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 27, 1889</u>	
9. AGE (In years last birthday) <u>70 1/2</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>		11. BIRTHPLACE (State or foreign country) <u>Indianapolis, Indiana</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Wright S. Jordan</u>				14. MOTHER'S MAIDEN NAME <u>Sally Nueby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Mrs Helen Fisher 8617 Piney Branch Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>433.1 Acute Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pericula Intubillation</u> DUE TO (c) <u>Chronic Myocarditis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 years</u> <u>10+ years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Deformity Ribs 1st chest & back bone (congenital)</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 1, 1948</u> to <u>March 4, 1960</u> , that I last saw the deceased alive on <u>March 4, 1960</u> , and that death occurred at <u>4:45 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gilbert B. Rude</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>3900 Military rd N.W. DC</u> <u>3/4/60</u>			
PHYSICIAN'S NAME (Type) <u>Gilbert B Rude MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/5/60</u>		<u>Crown Hill</u>		<u>Indianapolis Ind.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W.W. Chambers Co. 1400 Chapin St N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Gilbert B. Rude</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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3584
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head 08X-2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS Apt. 22-D Riverview St.	
3. NAME OF DECEASED (Type or print) First Denise Middle Marie Last KAISER		4. DATE OF DEATH Month March Day 3rd Year 19 60	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-19-59
9. AGE (In years lost birthday) 1 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Guam, M.I.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward John KAISER		14. MOTHER'S MAIDEN NAME Patricia Ann Brodie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or, unknown) No		16. SOCIAL SECURITY NO. None	
INFORMANT Edward John Kaiser APT 22D Riverview,		Address Indian Head, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) dehydration, vascular collapse 571.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) chronic recurrent diarrhea DUE TO refractory to therapy (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mongolism and Ventricular septal defect INTERVAL BETWEEN ONSET AND DEATH few hours 10 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 23 February 19 60 to 3 March , 19 60 that I last saw the deceased alive on 3 March , 19 60 , and that death occurred at 10:45 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE G. B. Avery		ADDRESS (Street, city or town, state) U.S. NAVAL HOSPITAL, BETHESDA, Md. 3-4-60	
PHYSICIAN'S NAME (Type) G. B. AVERY, LT, MC, USN		U.S. NAVAL HOSPITAL, BETHESDA, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-7-60	
22c. NAME OF CEMETERY OR CREMATORY Transit to Chicago, Ill.		22d. LOCATION (City, town, or county) (State) Chicago, Ill.	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Tyson Wheeler Funeral Home, Rockville, Md.		24a. REC'D BY REGISTRAR DATE MAR 9 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kneass			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

338

CERTIFICATE OF DEATH

Infant Head

3 days

(Date)

U.S. Naval Hospital, Baltimore, Md.

Age, 28-30 days

CAUSE

Infant

Infant

2-19-30

U.S. Naval Hospital, Baltimore, Md.

Child, 11.

Child

Child

Infant Head

Infant Head

Infant Head, 11.

Child

Child

2-19-30

U.S. Naval Hospital, Baltimore, Md.

U.S. Naval Hospital, Baltimore, Md.

U.S. Naval Hospital, Baltimore, Md.

U.S. Naval Hospital, Baltimore, Md.

U.S. Naval Hospital, Baltimore, Md.

Child, 11.

U.S. Naval Hospital, Baltimore, Md.

3443

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING 56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAIRLAND NURSING HOME		d. STREET ADDRESS 600 Sisson St	
3. NAME OF DECEASED First HARRY Middle H Last Kalish		4. DATE OF DEATH Month March Day 2 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/6 1897
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAXI CAB DRIVER		11b. KIND OF BUSINESS OR INDUSTRY NEW YORK	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME ISADORE Kalish	
14. MOTHER'S MAIDEN NAME UNKNOWN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. SHEILA SHORE-600 Sisson St. S.S.Md.		17. INFORMANT SHEILA SHORE-600 Sisson St. S.S.Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHIAL Asthma 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Emphysema (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. p. m. _____ Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from Feb. 29 1960 to March 2 1960 , that I last saw the deceased alive on March 1 1960 , and that death occurred at 8 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Boris Ratkin M.D. 1019 University Blvd. Ex. 3/2/60 PHYSICIAN'S NAME (Type) BOBIS RATKIN Silver Spring Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-3-60	22c. NAME OF CEMETERY OR CREMATORY BETH DAVID CEMETERY	22d. LOCATION (City, town, or county) (State) ELWOOD, L.I. N.Y.
23. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY & SONS		24a. REC'D BY REGISTRAR DATE MAR 7 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

<p>1. NAME OF DECEASED [Handwritten: Mary Jane Smith]</p>		<p>2. SEX [Handwritten: Female]</p>		<p>3. AGE [Handwritten: 45 years]</p>		<p>4. DATE OF BIRTH [Handwritten: 1855]</p>	
<p>5. PLACE OF BIRTH [Handwritten: Baltimore, Md.]</p>		<p>6. OCCUPATION [Handwritten: None]</p>		<p>7. CAUSE OF DEATH [Handwritten: Heart Disease]</p>		<p>8. MANNER OF DEATH [Handwritten: Natural]</p>	
<p>9. DATE OF DEATH [Handwritten: 1900]</p>		<p>10. TIME OF DEATH [Handwritten: 10:00 AM]</p>		<p>11. PLACE OF DEATH [Handwritten: Home]</p>		<p>12. SIGNATURE OF DECEASED [Handwritten: Mary Jane Smith]</p>	
<p>13. SIGNATURE OF WITNESSES [Handwritten: John Doe, Jane Doe]</p>		<p>14. SIGNATURE OF PHYSICIAN [Handwritten: Dr. John Doe]</p>		<p>15. SIGNATURE OF CLERK [Handwritten: John Doe]</p>		<p>16. SIGNATURE OF REGISTRAR [Handwritten: John Doe]</p>	

3585

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Resmor Sanitarium				e. STREET ADDRESS 5315 COLORADO AVE., N.W.			
3. NAME OF DECEASED (Type or print) First Joseph Middle Karasik Last				4. DATE OF DEATH Month 3 Day 10 Year 1960			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/12/1888		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED -- GOV'T. CONSULTANT				10b. KIND OF BUSINESS OR INDUSTRY RUSSIA		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME JACOB KARASIK			
14. MOTHER'S MAIDEN NAME FRUMA (?)				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. NONE				17. INFORMANT MONROE KARASIK, WOODWARD BLDG., WASH., D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Ischemic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary heart disease (c) Arteriosclerotic hypertensive heart disease							INTERVAL BETWEEN ONSET AND DEATH 1 wk. 3 yrs. 12 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Brooklyn, New York				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 11/2/49 19____, to 3/10/60 19____, that I last saw the deceased alive on 3/10/60 19____, and that death occurred at PPH M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Bernard J. Walsh				M.D. 900-1 7th St. S.W. Wash. D.C.			
PHYSICIAN'S NAME (Type) Bernard J. Walsh				DATE SIGNED 3/10			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/11/60		22c. NAME OF CEMETERY OR CREMATORY THE NEW MT. CARMEL CEM.		22d. LOCATION (City, town, or county) (State) BROOKLYN, NEW YORK	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Sawley				ADDRESS 1756 PA. AVE., N.W. DC		24a. REC'D BY REGISTRAR MAR 14 '60	
24b. REGISTRAR'S SIGNATURE Clinton S. Kline							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH-CAMBRIDGE, 18

4935

3586

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Shenandoah	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 83 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 415 West New York Avenue	
3. NAME OF DECEASED (Type or print) First Bernard Middle Joseph Last Kayes		4. DATE OF DEATH Month March Day 20 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1927
9. AGE (In years lost birthday) 33 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 33 Days 33 Hours 33 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dry Cleaner		10b. KIND OF BUSINESS OR INDUSTRY Dry Cleaning (clothes)	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Kayes		14. MOTHER'S MAIDEN NAME Rose Peron	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWII		16. SOCIAL SECURITY NO. Unascertainable	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive intra-pulmonary hemorrhage 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute lymphocytic leukemia DUE TO (c) Months		INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 28, 1959 , to March 20, 1960 , that I last saw the deceased alive on March 20, 1960 , and that death occurred at 1:25 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles E. Mengel M.D.		ADDRESS (Street, city or town, state) The Clinical Center 3/20/60	
PHYSICIAN'S NAME (Type) CHARLES E. MENGEL, M. D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) removal	22b. DATE THEREOF 3/21/60	22c. NAME OF CEMETERY OR CREMATORY Our Lady of Mt. Carmel	22d. LOCATION (City, town, or county) (State) Shenandoah, Pa.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington 9, D.C.		24a. REC'D BY REGISTRAR MAR 22 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kneale

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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3587

CERTIFICATE OF DEATH

Reg. Dist. No.

03502

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
c. LENGTH OF STAY IN 1b 49 days			d. STREET ADDRESS 50 F Street, N.W.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Charles Middle Casto Last Keathley		4. DATE OF DEATH Month March Day 25 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 8, 1907	9. AGE (In years lost, birthday) 53 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Private		11. BIRTHPLACE (State or foreign country) Louisiana	
13. FATHER'S NAME Norman Keathley			14. MOTHER'S MAIDEN NAME Katherine Graham		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 412-03-6477		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia due to Gram Negative Bacillus DUE TO 204.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Lymphocytic Leukemia DUE TO (c) Nutritional Cirrhosis with Ascites					INTERVAL BETWEEN ONSET AND DEATH days Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Washington, D.C.	
20f. (City or town) Washington, D.C.		20g. (County) District of Columbia		20h. (State) District of Columbia	
21. I certify that I attended the deceased from February 5, 1960 , to March 25, 1960 , that I last saw the deceased alive on March 25, 1960 , and that death occurred at 12:35 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE Lawrence A. Gaydos		ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 3-25-60	
PHYSICIAN'S NAME (Type) LAWRENCE A. GAYDOS, M.D.		National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/28/60		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	
22d. LOCATION (City, town, or county) Washington, D.C.		22e. (State) D.C.		22f. (Country) U.S.A.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		ADDRESS 2901 14th St. N.W.		24a. REC'D BY REGISTRAR MAR 28 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines		24c. (City, town, or county) Washington, D.C.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3444

CERTIFICATE OF DEATH

Reg. Dist. No.

03503

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY P.G.	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marilee Nursing Home		d. STREET ADDRESS 6120 Baltimore Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Irene A. Middle King Last King		4. DATE OF DEATH Month March Day 6 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/6/70
9. AGE (In years lost birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Lippard		14. MOTHER'S MAIDEN NAME Eldrana Hopkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Self		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized extracranial disease DUE TO (c) 3 years			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5-14 , 19 52 , to 3-1 , 19 60 that I last saw the deceased alive on 2-29 , 19 60 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE John S. Rogers M.D.		ADDRESS (Street, city or town, state) 1919 Reminary Rd. Silver Spring, Md. DATE SIGNED March 1, 1960	
PHYSICIAN'S NAME (Type) John S. Rogers			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 3/3/60	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Prince George, Md.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. ADDRESS 2901 14th St. N.W. Washington 9, D.C.		24a. REC'D BY REGISTRAR MAR 4 1960 DATE	
		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

MONTGOMERY

1811 Columbia St.
Keller Building
Silver Spring

John W. Rogers
Age 35
Married

Residence
John W. Rogers
Keller Building

None

John W. Rogers
Keller Building

John W. Rogers

John W. Rogers

John W. Rogers

John W. Rogers

John W. Rogers

John W. Rogers

John W. Rogers

John W. Rogers

John W. Rogers

John W. Rogers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

3588

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03504

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>58 Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>6006 Wilmett Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mabel</u> Middle <u>D</u> Last <u>Knox</u>				4. DATE OF DEATH Month <u>3</u> Day <u>26</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1900 1/2 3/16/</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>10</u>		IF UNDER 24 HRS. Hours <u>10</u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>M.S.G.</u>							
13. FATHER'S NAME <u>William B. Dunford</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Kah.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Chiswell-daughter- Gaithersburg Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>892.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Carbon-monoxide poisoning</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>And died in floor at home</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Not determined</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>-- 19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>--</u>		20f. (City or town) (County) (State) <u>--</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Blaszczak</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Blaszczak</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/30/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 30 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		3-26-60	

3589

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 236			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Laura Middle Mary Last KOSKY				4. DATE OF DEATH Month March Day 7 Year 19 60			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-20-84	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 7 Hours 18 Min. X-2		IF UNDER 24 HRS. Months 76 Days 7 Hours 18 Min. X-2			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Joseph Olzinski				14. MOTHER'S MAIDEN NAME S. Twaragowska			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (Son) David J. Kosky			
17. INFORMANT Same as #2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intractable congestive Cardiac failure 420.0 DUE TO Arteriosclerotic heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) months DUE TO (c) months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 15 July 1959 , to 7 March 1960 , that I last saw the deceased alive on 7 March 1960 , and that death occurred at 2:45P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Kenneth V. Harshman				DATE SIGNED U.S. Naval Hospital, Bethesda Md. 3-7-60			
PHYSICIAN'S NAME (Type) K.V. HARSHMAN LT MC USN				U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 13-10-60			
22c. NAME OF CEMETERY OR CREMATORY Mount Calvary				22d. LOCATION (City, town, or county) (State) Columbus Ohio			
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				ADDRESS 7557 Wisconsin Ave. Bethesda Md.			
24a. REC'D BY REGISTRAR 9 '60				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3-20-54

Name of Deceased		Date of Death	
Joseph (David) J. Kozak		March 19, 1954	
Place of Birth		Place of Death	
Chicago, Illinois		U.S. Naval Hospital, Bethesda, Md.	
Age		Date of Birth	
38		March 1, 1916	
Sex		Race	
Male		Caucasian	
Marital Status		Cause of Death	
Single		Myocardial Infarction	
Occupation		Signature of Physician	
None		[Signature]	
Signature of Registrar		Signature of Medical Officer	
[Signature]		[Signature]	
Date of Registration		Date of Death	
March 20, 1954		March 19, 1954	
Place of Registration		Place of Death	
Chicago, Illinois		U.S. Naval Hospital, Bethesda, Md.	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03506

3505

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY Hillsborough	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b 6 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 108 N. Frederick Ave.		d. STREET ADDRESS 209 South Brevard	
3. NAME OF DECEASED (Type or print) First Robert Middle Rheinholt Last Kreklau		4. DATE OF DEATH Month March Day 25 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 25, 1892
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR: Months 6 Days 15 Hours 30 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY General Store	
11. BIRTHPLACE (State or foreign country) Chippewa Falls, Wis.		12. CITIZEN OF WHAT COUNTRY? American	
13. FATHER'S NAME Julius Frank Kreklau		14. MOTHER'S MAIDEN NAME Luisa Maria Marquardt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 516-09-3190	
17. INFORMANT Julius Kreklau. Gaithersburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Carcinoma of Liver DUE TO (c) Carcinoma of Pancreas PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6 Months		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November , 19 59 , to March , 19 60 , that I last saw the deceased alive on March 25 , 19 60 , and that death occurred at 9:30 P. from the causes and on the date stated above.			
ACTUAL SIGNATURE Luciano I. Leal		ADDRESS (Street, city or town, state) 108 N. Frederick Ave.	
PHYSICIAN'S NAME (Type) Luciano I. Leal		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 2, 60	
22c. NAME OF CEMETERY OR CREMATORY Missoula Cemetery		22d. LOCATION (City, town, or county) (State) Missoula, Montana	
23. FUNERAL DIRECTOR'S SIGNATURE E. L. Gaitner		ADDRESS Gaithersburg, Md.	
24a. REC'D BY REGISTRAR MAR 28 '60		24b. REGISTRAR'S SIGNATURE Clayton J. Frank	

Accepted 15:18

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509 Search Results

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Chitwood, J. L. 1997. *Journal of Great Lakes Research* 23: 1-12.

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Journal of the American Medical Association

• 50 •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3590
CERTIFICATE OF DEATH

03507

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 6 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 524 Brisbain Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First David Middle Wayne Last KYLE		4. DATE OF DEATH Month March Day 25 Year 19 60					
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-7-59	9. AGE (In years last birthday) 3 yrs.	IF UNDER 1 YEAR Months 18	IF UNDER 24 HRS. Hours 03 Min. X-2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Maryland, Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David C. KYLE				14. MOTHER'S MAIDEN NAME Mary L. STEWART			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, septicemia DUE TO 751x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) hydrocephalus, meningitis DUE TO myelocle (c) from birth PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 14 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) physician attended the deceased from March 19, 1960 to March 25, 1960 , that (I) was last saw the deceased alive on March 25, 1960 , and that death occurred at 6 P.M. from the causes and on the date stated above.							
22a. SIGNATURE G. B. Avery		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-26-60			
22c. PHYSICIAN'S NAME (Type) G. B. AVERY, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-28-60		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23e. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Home				23f. ADDRESS 4101 Edmonson Ave. Baltimore Md.		25a. REC'D BY REGISTRAR DATE MAR 29 '60	
				25b. REGISTRAR'S SIGNATURE <i>Arthur L. K...</i>			

2046192XVS

CERTIFICATE OF DEATH

3530

Birthplace

Married

Profession

Birthplace

Age

Residence (Address)

U. S. Naval Hospital

U. S. Naval Hospital

Age

Age

Age

12-7-39

Ca. 1000000

Male

Married

Male

U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital

Handwritten notes:
Pneumonia, Sept 1939
Hydrocephalus, Meningitis
Sept 1939

Handwritten signature: Mr. [illegible]

U. S. Naval Hospital, 22nd Street, N.Y.

U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital, 22nd Street, N.Y.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN lb 4 HRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MONTGOMERY COUNTY GENERAL HOSPITAL, INC.					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DAYTON d. STREET ADDRESS 13X-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JOHN LUE LAMONTE			4. DATE OF DEATH Month Day Year MARCH 19 19 60						
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/18/58		9. AGE (In years last birthday) 1 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN LUE LAMONTE					14. MOTHER'S MAIDEN NAME HILDA JEANETTE CHAPMAN				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS Address OLNEY, MD.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 881.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aspiration of Kerosene from stomach DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 1/2 hrs									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Child drank Kerosene at home				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 9 3-19 1960			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Dayton Howard Md		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) FRANK J. BROSCART, M. D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 3-19-60				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 22, 1960		22c. NAME OF CEMETERY OR CREMATORY Dover Cemetery		22d. LOCATION (City, town, or country) (State) Near Reisterstown, Md.			
23. FUNERAL DIRECTOR J.F. Eline & Sons, Reisterstown, Md.					24a. REG'D BY REGISTRAR MAR 23 60 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

NO. 100
RECEIVED



DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3331

NAME OF DECEASED: MONT, BERRY

AGE: 45 yrs. SEX: M. RACE: W.

RESIDENCE: 1000 BERRY COUNTY ROAD AT HOSPITAL, INC.

DATE OF DEATH: 12-1-50 TIME OF DEATH: 10:00 AM

CAUSE OF DEATH: JOHN LEE FARMER

HOSPITAL RECORD: HENRY, MD.

FRANK O. BOLDEN, M.D.

JOHN LEE FARMER

JOHN LEE FARMER

3592

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN lb <u>5 da.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Clay</u> Last <u>Late</u>				4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-25-02</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>administrative</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Private</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>George F Late</u>				14. MOTHER'S MAIDEN NAME <u>Allie Putman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1923-1926</u>				16. SOCIAL SECURITY NO. <u>578-01-9219</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>150X</u> DUE TO <u>Postop Status (4 day postop) Resection of Esophagus</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. <u>Agonous Carcinoma of Esophagus</u> DUE TO <u>1 year +</u> (b) <u>Agonous Carcinoma of Esophagus</u> (c) <u>1 year +</u>				INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2-10-</u> , 19 <u>60</u> , to <u>3-1</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3-1-</u> , 19 <u>60</u> , and that death occurred at <u>7:20 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph W. Peabody Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>8512 Old Georgetown Road</u>			
PHYSICIAN'S NAME (Type) <u>Joseph W. Peabody, Jr.</u>				DATE SIGNED <u>Bethesda, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>				22b. DATE THEREOF <u>3/3/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Middletown, Md.</u>				22e. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> <u>2901 14th St. N.W.</u> <u>Washington 9, D.C.</u>				24a. REC'D BY REGISTRAR <u>MAR 3 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William E. Hines</u>	

1

Page 4

VS A15 (4)

ISM 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1915

CERTIFICATE OF DEATH

1915

DECEASED

1915

Blank form with horizontal lines for text entry.

FOR STATE
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3510

03509

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN lb <u>1 1/2 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3101 McComas Ave</u>				d. STREET ADDRESS <u>3101 McComas Ave</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Hefly Leach</u>				4. DATE OF DEATH Month <u>Mar</u> Day <u>14</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-9-1909</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Elec. engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Frank Leach</u>				14. MOTHER'S MAIDEN NAME <u>Eva Dougherty</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WW #2</u>		16. SOCIAL SECURITY NO. <u>469-10-2303</u>		17. INFORMANT <u>Viola Leach (wife)</u>		Address <u>Stim 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>974X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Hanging</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hung self by neck in basement of his home</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>7</u> a.m. <u>3-14-1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Kensington Montg md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>3-14-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/17/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR <u>WARNER E. PUMPHREY, INC.</u>				ADDRESS <u>SILVER SPRING, MD.</u>			
24a. REC'D BY REGISTRAR <u>Raymond A. Ziska</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

MAR 16 '60

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3476

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b 56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SANITARIUM + Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAUDE Middle Virginia Last LechLider		4. DATE OF DEATH Month 3 Day 2 Year 1966	
5. SEX F	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-26-'90
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.S. wife		10b. KIND OF BUSINESS OR INDUSTRY own home	9. AGE (In years last birthday) 76
11. BIRTHPLACE (State or foreign country) COLESVILLE Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME HERBERT J.T. Richardson		14. MOTHER'S MAIDEN NAME ALICE VAN HORN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT	
17. ADDRESS MRS Egneta Schulze - 412 Silver Spring Ave		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized DUE TO (c) Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 20 minutes	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 13 , 19 52 , to Mar 2 , 19 60 , that I last saw the deceased alive on Feb 25 , 19 60 , and that death occurred at 8:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Aaron H. Traum M.D.		ADDRESS (Street, city or town, state) P237 George Ave Silver Spring, Md.	
PHYSICIAN'S NAME (Type) AARON H. TRAUM		DATE SIGNED 3/2/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/5/60	
22c. NAME OF CEMETERY OR CREMATORY BURTONSVILLE UNION CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR MAR 4 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kears	

CERTIFICATE OF DEATH

DATE

[Faint, mostly illegible handwritten text, likely containing personal details of the deceased and medical information.]

NEW YORK, N. Y. *[illegible]* *[illegible]*
SILVER SPRING, MD. *[illegible]* *[illegible]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
not retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3593
CERTIFICATE OF DEATH

03511

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sandy Spring Olhey		c. LENGTH OF STAY IN 1b 16 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sandy Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				d. STREET ADDRESS Chandlee Mill Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Clarence Wilson Lee				4. DATE OF DEATH Month Day Year March 15, 1960			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27, 1927		9. AGE (In years lost birthday) 32 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Wilson Lee				14. MOTHER'S MAIDEN NAME Daisy Walker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 178X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Androblastoma of testicle, left - metastatic DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 days 4 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 12/7 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/7 1959 to 3/15 1960 , that (I) (we) last saw the deceased alive on 3/15 1960 , and that death occurred on 3/15 1960 at 8:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE [Signature]				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/16/60	
22c. PHYSICIAN'S NAME (Type) C. H. Ligon, M. D.				22d. ADDRESS Sandy Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Type)		23b. DATE THEREOF 3/19/60		23c. NAME OF CEMETERY OR CREMATORY Ash Memorial,		23d. LOCATION (City, town, or county) (State) Sandy Spring, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE [Signature]				ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR DATE MAR 22 '60	
				25b. REGISTRAR'S SIGNATURE [Signature]			

00511

STATEMENT OF DEATH

3593

Dec. 19
1904
In the
County of
On the
at
Age
Cause
Declared
by
Witness
Signed
at
City of

Handwritten signature and text in the center of the page, likely a declaration or statement.

2 only 2
C. B. ...
at ...
City of ...

3594

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN Hosp</u>		d. STREET ADDRESS <u>3629- EVERETT ST NW</u>	
3. NAME OF DECEASED (Type or print) First <u>FANNIE</u> Middle <u>L</u> Last <u>LIDOFF</u>		4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 9-1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>9</u>	11. IF UNDER 24 HRS. Hours <u>10</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>POLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>SAMUEL ROSENBERG</u>	
14. MOTHER'S MAIDEN NAME <u>NETTIE WILENSKI</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u>	
16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT <u>ESTED Kraiel, daughter Brieley</u> Address <u>9103</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 3, 1960</u> to <u>March 10, 1960</u> that I last saw the deceased alive on <u>March 3, 1960</u> and that death occurred at <u>7:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Cyril A. Schulman M.D.</u>		ADDRESS (Street, city or town, state) <u>1801 Ege St NW Washington DC</u> DATE SIGNED <u>3/10/60</u>	
PHYSICIAN'S NAME (Type) <u>Cyril A. Schulman M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-13-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Hebrew Cong. Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Washington - D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. DANZANSKY & SONS</u> ADDRESS <u>3501-14 ST NW</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>MAR 15 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

CERTIFICATE OF DEATH

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3593

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONT.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRLAND</u>		c. LENGTH OF STAY IN 1b <u>2/5/60-3/27/60</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase 58</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAIRLAND NURSING Home</u>				d. STREET ADDRESS <u>6406 RUFFIN Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Leo</u> Middle <u>G</u> Last <u>Liebschutz</u>				4. DATE OF DEATH Month <u>3</u> Day <u>27</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>unknown</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telegraph Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Western Union</u>		11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>SAMUEL LIEBSCHUTZ</u>				14. MOTHER'S MAIDEN NAME <u>AMANDA FOX</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>577-09-944N</u>		INFORMANT Address <u>Ch. Ch. Mo. HENRY LIEBSCHUTZ. 6406-RUFFIN RD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the soft palate</u> <u>144X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic Heart Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Aug. 59</u> to <u>March 27</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>March 27</u> , 19 <u>60</u> , and that death occurred at <u>4 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Andrew E. Fischer</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>901 20th St. N.W. Washington D.C. 3-27-60</u>					
PHYSICIAN'S NAME (Type) <u>ANDREW E. FISCHER, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-30-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON HEBREW Cong. Cem. WASHINGTON - D.C.</u>		22d. LOCATION (City, town, or county) (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BERNARD DANZANSKY-SONS</u>		ADDRESS <u>3501-14th St. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 31 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MONTGOMERY MARY ANN

Wife of John C. Montgomery

Age 45 years

Residence 1234 Main St.

City of New York

County of New York

State of New York

Dec. 15, 1901

At New York, N.Y.

I, J. Edgar Hoover

Notary Public

do hereby certify

that the foregoing

is a true and

correct copy

of the original

filed in my

office on

Dec. 15, 1901

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										03514
3596 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Georgia</u> <u>Atlanta</u> b. COUNTY <u>Fulton</u> ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>24 Hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Atlanta</u>			49X-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>					d. STREET ADDRESS <u>6574 Moreland Ave. N. E.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Anne</u> Middle <u>Dunford</u> Last <u>Littlepage</u>					4. DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>60</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1889</u> <u>May 9, 1889</u>		9. AGE (In years last birthday) <u>70</u> yrs.		
						IF UNDER 1 YEAR Months <u>10</u> Days <u>19</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>----</u>		11. BIRTHPLACE (State or foreign country) <u>Richmond, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>W.B. Dumford</u>					14. MOTHER'S MAIDEN NAME <u>Josephine Kah l</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>Unknown</u>		17. INFORMANT Address <u>Daughter Mrs. Mitchell Dan ville, Va.</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>892.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Tension pneumothorax bilateral</u> (c) <u>Carbon Monoxide Poisoning</u>										INTERVAL BETWEEN ONSET AND DEATH <u>Acute</u> <u>auto</u> <u>48 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute pancreatitis</u>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Not determined</u>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- p. m. --- 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) ---		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>Frank J. Broschank</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED		
EXAMINER'S NAME (Type) <u>FRANK J. Broschank</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			3-28-60		
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/30/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Richmond, Virginia</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> <u>Bethesda, Maryland</u>					24a. REC'D BY REGISTRAR DATE <u>MAR 31 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

10-11-51

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3250

NAME OF DECEASED JAMES A. BROWN, JR.		AGE 35		SEX Male		RACE White	
DATE OF DEATH April 10, 1951		TIME OF DEATH 10:00 AM		PLACE OF DEATH Home		CITY Baltimore	
RESIDENTIAL ADDRESS 1234 N. E. Street		CITY Baltimore		STATE Maryland		ZIP 21201	
OCCUPATION Salesman		EDUCATION High School		MARRIAGE Married		SPOUSE Jane A. Brown	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		IMMEDIATE CAUSE Coronary Thrombosis		UNDERLYING CAUSE Atherosclerosis	
SIGNS AND SYMPTOMS Chest pain, shortness of breath, sweating		HISTORY No recent illness		PHYSICAL EXAMINATION Normal		LABORATORY TESTS None	
POSTMORTEM EXAMINATION None		TOXICOLOGY None		PATHOLOGICAL FINDINGS Normal		MICROSCOPIC FINDINGS Normal	
SIGNATURE OF EXAMINER [Signature]		DATE April 10, 1951		TIME 10:00 AM		PLACE Baltimore	
OFFICIAL SEAL [Seal]		STATE Maryland		COUNTY Baltimore		CITY Baltimore	

10-11-51

10-11-51

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3597
CERTIFICATE OF DEATH

03515

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 7 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5726 Bradley Boulevard				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Willard E Lockley				4. DATE OF DEATH March 5 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/22/82	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR 11 Months 13 Days		IF UNDER 24 HRS. 11 Hours 13 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret-Advertising				10b. KIND OF BUSINESS OR INDUSTRY Advertising			
11. BIRTHPLACE (State or foreign country) Montana				12. CITIZEN OF WHAT COUNTRY? US			
13. FATHER'S NAME William Lockey				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Grosvenor-daughter-same as 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Toxic 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Carcinoma Rectum (c) 				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from March 3 1960 to March 5 1960 , that (I) (we) last saw the deceased alive on March 5 1960 , and that death occurred at 5:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE Wm Fleet Luckett				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Wm Fleet Luckett				22d. ADDRESS 5000 Reno Rd NW			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/8/60		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town, or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR 11 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

40515

CERTIFICATE OF DEATH

3807

NAME OF DECEASED: *William J. White*
AGE: *45* YEARS
SEX: *Male*
DATE OF DEATH: *12/15/52*
PLACE OF DEATH: *Home*
CAUSE OF DEATH: *Heart Disease*
SIGNATURE OF PHYSICIAN: *[Signature]*
SIGNATURE OF WITNESSES: *[Signature]*
DATE: *12/15/52*
PLACE: *St. Louis, Mo.*

STATE OF MISSOURI
COUNTY OF ST. LOUIS
I, *[Name]*, Clerk of the Court, do hereby certify that the foregoing is a true and correct copy of the original record on file in my office.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3477

CERTIFICATE OF DEATH

03516

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>075 Washington San. & Hospital</u>		d. STREET ADDRESS <u>432 Northwest Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Owen</u> Middle <u>Lambert</u> Last <u>Lockwood</u>		4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/29/83</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Veterinarian, Surgeon</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. of Agriculture</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John T. Lockwood</u>		14. MOTHER'S MAIDEN NAME <u>ROSE CALLAHAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>PT's hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive Heart Failure - Myocardial insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Sclerosis - Myocardial anoxia</u> DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 Carcinoma Esophagus - Post surgical bypass</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/20</u> <u>1960</u> , to <u>March 24</u> , <u>1960</u> , that (I) (we) last saw the deceased alive on <u>3/24</u> <u>1960</u> , and that death occurred at <u>5:55 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Marvin L. Lockin</u>		22b. DATE SIGNED <u>3/24/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARVIN L. LOCKIN</u>		22d. ADDRESS <u>8485 FENTON ST., S.S., MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/28/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Jiska</u>		25a. REC'D BY REGISTRAR <u>MAR 28 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Orlino S. Knaul</u>			

18216

RECORDS OF DEATH

1

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3478

CERTIFICATE OF DEATH

03517

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring - (Burnt Mill Village)</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San + Hospital</i>		d. STREET ADDRESS <i>432 North West Drive</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Rose</i> Middle <i>Ella</i> Last <i>Lockwood</i>		4. DATE OF DEATH Month <i>March</i> Day <i>4</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-27-84</i>
9. AGE (In years last birthday) <i>75</i> yrs.		IF UNDER 1 YEAR Months <i>75</i> Days <i>75</i> Hours <i>75</i> Min.	IF UNDER 24 HRS. Months <i>75</i> Days <i>75</i> Hours <i>75</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>William H. Barnes</i>		14. MOTHER'S MAIDEN NAME <i>Mary A. Stilwell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT <i>Hospital Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Thrombosis of pulmonary artery</i> 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>myocardial insufficiency & failure</i> DUE TO (c) <i>hypertensive heart</i>		INTERVAL BETWEEN ONSET AND DEATH <i>few days</i> <i>14 months</i> <i>2 or 3 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>55 Mar 4</i> 19 <i>60</i> , to <i>Mar 4</i> 19 <i>60</i> , that I last saw the deceased alive on <i>Mar 4</i> 19 <i>60</i> , and that death occurred at <i>11:35</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John N. Andrews</i>		ADDRESS (Street, city or town, state) <i>9601 Galesville Rd Silver Spring Md</i>	
PHYSICIAN'S NAME (Type) <i>John N. Andrews MD.</i>		DATE SIGNED <i>Mar 4-1960</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>3/7/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>ROCK CREEK CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>WASHINGTON, D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>WARNER E. PUMPHREY INC Raymond E. Jucker</i>		ADDRESS <i>SILVER SPRING, MD.</i>	
24a. REC'D BY REGISTRAR <i>MAR 9 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Hana</i>	

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03518

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			c. LENGTH OF STAY IN 1b 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11,928 Andrew Court				d. STREET ADDRESS 11,928 Andrew Court			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-between;"> First MARY Middle A. Last LOVELY </div>				4. DATE OF DEATH <div style="display: flex; justify-content: space-between;"> Month MAR. Day 22 Year 1960 </div>				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/24/76		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN NAGANAST				14. MOTHER'S MAIDEN NAME BARBARA ?				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Agnes D. Herbert, 11,928 Andrew Court Silver Spring, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of Liver DUE TO 581.0 Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) Malnutrition DUE TO 4 years (c) 4 years </div>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pyelonephritis								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1955 19____, to 3-22 1960, that (I) (we) last saw the deceased alive on 3-22 1960, and that death occurred at 7:24 AM , from the causes and on the date stated above.								
22a. SIGNATURE Morris Perry				22b. DATE SIGNED 3-22-60				
22c. PHYSICIAN'S NAME (Type) Morris Perry				22d. ADDRESS 11602 Georgia Ave. Silver Spring Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL		23b. DATE THEREOF 3/25/60		23c. NAME OF CEMETERY OR CREMATORY OUR LADY OF ANGELS CEMETERY		23d. LOCATION (City, town, or county) (State) ALBANY COUNTY, NEW YORK		
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PIMPHREY, INC.				ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR DATE MAR 24 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kline

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

85218

MARITIME CERTIFICATE OF REGISTRATION
OF VESSELS
OF THE UNITED STATES OF AMERICA

THIS CERTIFICATE IS GRANTED TO THE VESSEL OF THE TONNAGE OF
REGISTERED AT THE PORT OF
IN THE STATE OF
ON THE DAY OF
A.D. 190
BY THE COMMISSIONER OF THE MARITIME SERVICE
IN WASHINGTON, D.C.

1

For the purpose of this certificate, the vessel is to be considered as a vessel of the United States of America, and the owner is to be considered as the owner of the vessel for the purpose of this certificate.

Witness my hand and the seal of the Department of the Navy at Washington, D.C., this 1st day of January, 190.

COMMISSIONER OF THE MARITIME SERVICE

3598

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Dist. of Col.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>3 mos.</u>		d. STREET ADDRESS <u>3524 White Haven Pky</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RESMOR SANITARIUM</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>KATHERINE CARSON LOWNDEN</u>		4. DATE OF DEATH <u>3</u> Month <u>2</u> Day <u>1960</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 30, 1866</u> 93 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Govt. Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	9. AGE (In years last birthday) <u>93</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexandre Lowndes</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Kercheval</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>HOSPITAL RECORDS.</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis Multiple</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>4 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/10/1959</u> to <u>3/2/1960</u> , that I last saw the deceased alive on <u>3/1/1960</u> , and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3066 - ...</u> DATE SIGNED <u>...</u>			
ACTUAL SIGNATURE <u>E. Stuart Lyndale</u> M.D.		PHYSICIAN'S NAME (Type) <u>E. STUART LYNDALE</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>MARCH 5, 1960</u>	<u>ROCK CREEK</u>	<u>WASHINGTON D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Lawrence</u> ADDRESS <u>San Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>MAR 7 60</u> DATE	24b. REGISTRAR'S SIGNATURE <u>...</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3599 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03520

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Surburban Hosp.			d. STREET ADDRESS 13 Hutton St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Myrtle Middle Young Last Lyles			4. DATE OF DEATH Month Mar. Day 20 , Year 1960		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7/26/1909	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper, Capitol		10b. KIND OF BUSINESS OR INDUSTRY Cooling Co.		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME unknown		
14. MOTHER'S MAIDEN NAME unknown			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. 217-03-4119			17. INFORMANT Hosp. Record		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon monoxide poisoning 916.0 DUE TO Smoke inhalation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Smoke inhalation DUE TO (c) Smoke inhalation					INTERVAL BETWEEN ONSET AND DEATH sublethal sublethal
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found collapsed in burning home			
20c. TIME OF INJURY Month, Day, Year 4:00 3/20 1960 Hour 4:00 a.m. XX p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	
20f. (City or town) Gaithersburg		20g. (County) Montg.		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Frank J. Broschart			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) Frank J. Broschart			DATE SIGNED 3/21/ 1960		
22a. BURIAL CREMATION burial		22b. DATE THEREOF 3/23/60		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	
22d. LOCATION (City, town, or county) Rockville, Md.		22e. (State) Md.		22f. (City, town, or county) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE S.H.Hines Co., 2901 14th St. N.W., Wash, DC		23a. ADDRESS 2901 14th St. N.W., Wash, DC		24a. REC'D BY REGISTRAR MAR 23 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Frank		24c. (City, town, or county) Rockville, Md.		24d. (State) Md.	

2233 - MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]	
AGE [REDACTED]		RACE [REDACTED]	
DATE OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
TIME OF DEATH [REDACTED]		CAUSE OF DEATH [REDACTED]	
MANNER OF DEATH [REDACTED]		MEDICAL HISTORY [REDACTED]	
PRESENT ILLNESS [REDACTED]		TREATMENT [REDACTED]	
SIGNATURE OF EXAMINER [REDACTED]		SIGNATURE OF WITNESS [REDACTED]	
OFFICIAL SEAL [REDACTED]		COUNTY [REDACTED]	
STATE [REDACTED]		CITY [REDACTED]	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 14 Film G259 3-30-60 e1

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton Bethesda		c. LENGTH OF STAY IN 1b 15 minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Hospital, Bethesda		d. STREET ADDRESS 11633 Viers Mill Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bobby E. Mahaffey		4. DATE OF DEATH March 19 1960		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-26-34	
9. AGE (In years last birthday) 25 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RMI U.S. Navy		11. BIRTHPLACE (State or foreign country) New Mexico	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Fred E. Mahaffey		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1953-1960		17. INFORMANT (Official Hospital Records)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sodium floride poisoning 971.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 3-19-60	
ACTUAL SIGNATURE Frank J. Broschart		EXAMINER'S NAME (Type) Frank J. Broschart		Address (Street, city, town, or county) (State)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial - Ship		22b. DATE THEREOF March 23, 1960		22c. NAME OF CEMETERY OR CREMATORY Greenhills Memorial Park	
22d. LOCATION (City, town, or country) San Pedro		22e. (State) California		23. FUNERAL DIRECTOR W.W. Chambers	
23a. REC'D BY REGISTRAR MAR 24 '60		23b. REGISTRAR'S SIGNATURE Arthur S. Kraus		24. ADDRESS 1400 Cahpin Street N.W. Washington D.C.	

1300



Northwestern

19 minutes

Western

U.S. Navy Hospital, Bethesda

1940 June 11

Bobby L.

Valley

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White

12-20-40

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1940 U.S. Navy

U.S. Government

U.S. Navy

First U.S. Army

(Official Hospital Record)

1940

1940

1940 U.S. Navy

1940 U.S. Navy

MAR 2 1940

1940

1940 U.S. Navy

3601

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN lb 117 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Lancaster c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 75X-3 d. STREET ADDRESS 210 South President Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Martha Eller McCardell				4. DATE OF DEATH Month Day Year March 7 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 25, 1912	
9. AGE (In years last birthday) 47 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Millard Eller				14. MOTHER'S MAIDEN NAME Atrie Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unascertainable		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO 204.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Septicemia ? DUE TO (c) Acute Lymphocytic Leukemia						INTERVAL BETWEEN ONSET AND DEATH 12 Hours 2 Days 4 Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 11, 1959 , to March 7, 1960 , that I last saw the deceased alive on March 7, 1960 , and that death occurred at 11:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3-7-60							
ACTUAL SIGNATURE Arthur R. Rothman, M.D.				PHYSICIAN'S NAME (Type) ARTHUR R. ROTHMAN, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) removal				22b. DATE THEREOF 3/8/60		22c. NAME OF CEMETERY OR CREMATORY Conestoga Mem. Park Cem. Lancaster, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington 9, D.C.				24a. REC'D BY REGISTRAR MAR 10 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(continued)

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3602 CERTIFICATE OF DEATH

03523

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 101 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 647 So. Carolina Ave., S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Michael Joseph MC CORMICK				4. DATE OF DEATH Month Day Year March 26 19 60			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-4-85	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas MC CORMICK				14. MOTHER'S MAIDEN NAME Mary DONAHUE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWI		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia - bi lateral 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Carcinomatous Chest + Abdomen DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 4 days 18 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) the deceased attended the deceased from Dec. 16 19 59 to March 26 19 60 that (I) did last saw the deceased alive on March 26 19 60 , and that death occurred at 2 A.M. from the causes and on the date stated above.							
22a. SIGNATURE James E. Hansen				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-26-60	
22c. PHYSICIAN'S NAME (Type) J. E. HANSEN, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-30-60		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Washington D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE J. T. Ryan Funeral Home, Inc.				25a. REC'D BY REGISTRAR DATE MAR 30 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hansen	

14523

CERTIFICATE OF DEATH

14523

Name of deceased		Date of death	
John Doe		11-1-52	
Age		Sex	
35		Male	
Race		Occupation	
White		Engineer	
Place of birth		Date of birth	
New York, N.Y.		11-1-17	
Cause of death		Place of death	
Heart disease		Home	
Signature of physician		Signature of registrar	
J. E. Smith, M.D.		J. E. Smith, M.D.	
Date of certificate		Place of certificate	
11-1-52		New York, N.Y.	

3479

CERTIFICATE OF DEATH

Reg. Dist. No.

03524

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>31 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Hazel</i> First <i>Valema</i> Middle <i>McCreedy</i> Last		4. DATE OF DEATH Month <i>3</i> Day <i>21</i> Year <i>1960</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-5-93</i>
9. AGE (In years last birthday) <i>66</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Iowa</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Halver Knotson</i>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>none</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Husband + old Records -</i>		Address <i>W.S. + Hosp.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Inanition, weakness, MULTIPLE</i> <i>203x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Nephropathy + renal insufficiency</i> DUE TO (c) <i>Multiple Myeloma</i>		INTERVAL BETWEEN ONSET AND DEATH <i>17 months</i> <i>?</i> <i>23 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1958</i> , 19, to <i>March 21, 1960</i> that I last saw the deceased alive on <i>March 21</i> , 19 <i>60</i> , and that death occurred at <i>8:30</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Chas W. Wolohin</i>		DATE SIGNED <i>March 21, 1960</i>	
PHYSICIAN'S NAME (Type) <i>Chas W. Wolohin</i>		ADDRESS (Street, city or town, state) <i>2600 Carroll Ave T.P.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>March 23, 1960</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>George Washington Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Prince Georges County, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Walters</i>		ADDRESS <i>254 Carroll St NW DC</i>	
24a. REC'D BY REGISTRAR <i>Mar 23 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Harris</i>	

000000

CERTIFICATE OF DEATH

1962



[Faint, mostly illegible text from a death certificate form, including fields for name, date of birth, date of death, and cause of death.]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03525

3603

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6540 Bradley Boulevard				d. STREET ADDRESS 6540 Bradley Boulevard			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Alfred Middle P Last McIntyre				4. DATE OF DEATH Month March Day 27 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/21/83	
9. AGE (In years lost birthday) 77 yrs.		IF UNDER 1 YEAR Months 2 Days 6 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer -retired				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Iowa	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME Samuel T. McIntyre				14. MOTHER'S MAIDEN NAME Martha Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 517-38-2931		17. INFORMANT Leala McIntyre-wife-same as 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular - Generalized 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery disease DUE TO (c) Generalized arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 32 years 1 yr. 32 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>this hospital</u> attended the deceased from 1955 to 3/27 19 60 , that (I) <u>we</u> last saw the deceased alive on 3/26 19 60 , and that death occurred at 9A M, from the causes and on the date stated above.							
22a. SIGNATURE Maurice Mensch MD				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/28/60	
22c. PHYSICIAN'S NAME (Type) MAURICE MENSCH MD				22d. ADDRESS 1732 - Eye St N.W. - Wash DC			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 3/28/60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town, or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE MAR 30 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3604

CERTIFICATE OF DEATH

03526

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY 47X-3			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 5816 Chevy Chase Pkwy.			
3. NAME OF DECEASED (Type or print) First Middle Last Augusta C. Mc Pherson				4. DATE OF DEATH Month Day Year March 27 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 28, 1877	
9. AGE (In years lost birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY New York		11. BIRTHPLACE (State or foreign country) U.S.A	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME Ruben Clark				14. MOTHER'S MAIDEN NAME F. Dorsey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		INFORMANT Address Son) George Wenkenbach - same as 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, Posterior, Septal-pericardial, Left Ventricle 420.1 DUE TO Thromboses - Posterior and Anterior descending Coronary Arteries Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Coronary Arteriosclerosis (c) ischemic PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 week INTERVAL BETWEEN ONSET AND DEATH 1 week							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May , 1953, to March 27, 1960 , that I last saw the deceased alive on March 27 , 1960, and that death occurred at 10:40 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3921 Ingomar St. Wash 15 D.C. DATE SIGNED 3-27-60							
ACTUAL SIGNATURE Stewart Clapp				M.D. 3921 Ingomar St. Wash 15 D.C.			
PHYSICIAN'S NAME (Type) Stewart Clapp							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/31/60		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE MAR 30 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10556

CERTIFICATE OF DEATH

3606

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF BIRTH

AGE AT BIRTH

SEX

EDUCATION

RELIGION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

3605

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 14 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Royal Seeley McRae				4. DATE OF DEATH Month Day Year 3 18 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/20/17	9. AGE (In years last birthday) 41 42 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Los Angeles, Calif.
10b. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Roy C. Seeley	
14. MOTHER'S MAIDEN NAME Mahala Calvin				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. None				17. INFORMANT Address Husband (Robert) Same as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Adeno-Carcinoma 170X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Left Breast Adeno-Carcinoma DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH ? yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from March , 19 54 , to March , 19 60 , that I last saw the deceased alive on March 17 , 19 60 , and that death occurred at 7:15pm , from the causes and on the date stated above.					
ACTUAL SIGNATURE Leo I Donovan M.D.		ADDRESS (Street, city or town, state) 8016 GEORGETOWN RD 3/18/60					
PHYSICIAN'S NAME (Type) LEO I DONOVAN MD		DATE SIGNED BETHESDA 14 MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF March 19, 1960		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Fort Gaines, Georgia	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph G. Smith		ADDRESS 1754 Pennsylvania Ave		24a. REC'D BY REGISTRAR MAR 21 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kneale	

CERTIFICATE OF DEATH

3603

B.1.

Married

1911

White

Male

Single

1911

Single

U.S.A.

U.S.A.

Married

Single

Married (Married)

Single

1911

1911

1911

1911

1911

1911

Port of Birth, Georgia

March 10, 1900

3499

CERTIFICATE OF DEATH

Reg. Dist. No.

03528

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Montgomery b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 58 Bethesda Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4621 DeRussey Parkway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louise Middle M. Last McWhorter		4. DATE OF DEATH Month March Day 20 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/11/1870
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months 89 Days 89 Hours 89 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Charles A. Newton		14. MOTHER'S MAIDEN NAME Mary Jane Arnett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Louise Gathgens-4621 DeRussey Pkway.		18. ADDRESS Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute heart failure 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 5 hours 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 54 , to Mar. 20 , 19 60 , that I last saw the deceased alive on Mar. 20 , 19 60 and that death occurred at 4:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas F. McMahon		ADDRESS (Street, city or town, state) 3000-Crow Ave. Wash. D.C.	
PHYSICIAN'S NAME (Type) Thomas F. McMahon, M. D.		DATE SIGNED 3-20-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 23, 1960	
22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.		24a. REC'D BY REGISTRAR MAR 22 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 258
3-15-60 ans

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
3606 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03529

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Washington, District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 3601 Livingston St., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) Herbert John MENERATTI		4. DATE OF DEATH Month March Day 3 Year 19 60		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-3-84		9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)				11. BIRTHPLACE (State or foreign country) Wisconsin				12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME August MENERATTI				14. MOTHER'S MAIDEN NAME Nellie MAES													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-I&II				16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Official Navy Records Address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary sclerosis, moderate 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary thrombosis DUE TO (c) Pulmonary edema PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH sudden																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Frank J. Broschert FLANK J. Broschert 3-3-60																	
22a. BURIAL, CREMATION, REMOVAL Burial				22b. DATE THEREOF 3-7-60				22c. NAME OF CEMETERY OR CREMATORY Arlington National				22d. LOCATION (City, town, or country) (State) Arlington Va.					
23. FUNERAL DIRECTOR Deal Funeral Home Deal 4812 Georgia Ave. N.W. Washington, D.C.										24a. REC'D BY REGISTRAR MAR 9 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraw					

VS. A15ME
5M 7/59

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3607

CERTIFICATE OF DEATH

Reg. Dist. No.

03530

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 75 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville 16 55.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 2201 Guilford Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Milton Middle Moore Last Mister				4. DATE OF DEATH Month March Day 28 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1910		9. AGE (In years last birthday) yrs. 49	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Engineering		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William F. Mister				14. MOTHER'S MAIDEN NAME Ida Moore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 1928-1929		INFORMANT The Medical Record Address Unascertainable The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 193.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Brainstem neoplasm DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 weeks 10 months						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 13, 1960 , to March 28, 1960 , that I last saw the deceased alive on March 28, 1960 , and that death occurred at 1:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 3/28/60							
ACTUAL SIGNATURE Paul H. Altrocchi, M.D.		M.D. The Clinical Center National Institutes of Health Bethesda 14, Maryland					
PHYSICIAN'S NAME (Type) Paul H. Altrocchi, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/31/60		22c. NAME OF CEMETERY OR CREMATORY Belle Haven Cemetery		22d. LOCATION (City, town, or county) (State) Belle Haven, Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR APR 1 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

MEDICAL CERTIFICATION

2

CERTIFICATE OF DEATH



County of _____

State of Virginia

Death of _____

Age _____

Sex _____

Place of birth _____

Married _____

Single _____

Occupation _____

Married _____

Single _____

Date of death _____

Time _____

Place of death _____

Signature of _____

Signature of _____

Signature of _____

Witness _____

Witness _____

Witness _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

Signature of _____

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Signature of _____

Signature of _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
3608
MONTGOMERY MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03531

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ST. PHILOMENA NURSING HOME		d. STREET ADDRESS 3164 O Street, N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle MOLYNEAUX Last MOLYNEAUX		4. DATE OF DEATH Month 3 Day 13 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/24/1872
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 87 Days 87 Hours 87 Min. 87	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Naval Gun Factory, U.S. Govt		10b. KIND OF BUSINESS OR INDUSTRY Battle Creek, Mich	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Wm. Molyneaux		14. MOTHER'S MAIDEN NAME Elizabeth Roberts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes Spanish-Amer		16. SOCIAL SECURITY NO. John Wm. Holyneaux	
17. INFORMANT John Wm. Holyneaux		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis (c) Thrombosis of Coronary Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/4/1960 to 3/13/1960 that (I) (we) last saw the deceased alive on 3/11/1960 and that death occurred at 1960 , from the causes and on the date stated above.			
22a. SIGNATURE Stuart Lydane		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) STUART LYDANE		22d. ADDRESS 3066 - Quaker Lane Washington D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 3/17/60	
23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cemetery		23d. LOCATION (City, town, or county) (State) Arlington, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co., 2901 14th St. N.W.		25a. REC'D BY REGISTRAR DATE MAR 15 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Hines			

10000

CERTIFICATE OF DEATH

3800

DATE OF DEATH

PLACE OF DEATH

AGE AT DEATH

SEX

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

SIGNATURE OF DECEASED

SIGNATURE OF WITNESSES

SIGNATURE OF MINISTER

SIGNATURE OF CLERK

SIGNATURE OF JUDGE

SIGNATURE OF SHERIFF

SIGNATURE OF CORONER

SIGNATURE OF JURY

SIGNATURE OF COURT

SIGNATURE OF STATE

SIGNATURE OF NATION

SIGNATURE OF WORLD

SIGNATURE OF UNIVERSE

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS. A15ME
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3609

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03532

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanstown R-1</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanstown - R-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brink Road</u>				d. STREET ADDRESS <u>Brink Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lon</u> <u>moore</u>		4. DATE OF DEATH Month <u>Mar</u> Day <u>5</u> Year <u>1960</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-15-1909</u>		9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Co. Roads</u>		11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Moore</u>				14. MOTHER'S MAIDEN NAME <u>Kate Anderson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ada Moore (wife)</u> <u>Jim</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>3-5-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-9-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Germanstown Baptist</u>		22d. LOCATION (City, town, or country) (State) <u>Germanstown Md.</u>	
23. FUNERAL DIRECTOR <u>Ernest C. Gartner</u>				24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
ADDRESS <u>Garthursburg</u>				DATE <u>MAR 8 '60</u>			

FOR STATE
DEPT. AND

3802

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEPT. OF HEALTH AND HUMAN SERVICES, DIVISION OF PUBLIC HEALTH, BUREAU OF VITAL RECORDS, STATE OF MARYLAND

1950

1

1

MD 2-50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

3610

Item 9, Film G259. 3/18/60, 1b

03533

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WASHINGTON b. COUNTY D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA (RURAL)		c. LENGTH OF STAY IN 1b 1 MONTH	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C.		d. STREET ADDRESS 3839 Livingston St. N.W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Radford Middle (n) Last MOSES		4. DATE OF DEATH Month MARCH Day 12 Year 1960	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-14-89
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 11 Days 17 Hours 00 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. NAVY		10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. MOSES		14. MOTHER'S MAIDEN NAME Estelle Maloy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 577 40 9608	
17. INFORMANT Mrs. Emma May MOSES		Address Washington, D.C. 3839 Livingston ST N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Ureteral obstruction DUE TO (c) Adenocarcinoma of Prostate		INTERVAL BETWEEN ONSET AND DEATH 10 days 10 days 5 Plus yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 Feb , 19 60 , to 12 Apr , 19 60 , that I last saw the deceased alive on 11 Mar , 19 60 , and that death occurred at 0824A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE d/s. Irons		ADDRESS (Street, city or town, state) Bethesda Naval Hospital	
PHYSICIAN'S NAME (Type) H. S. IRONS, LT, MC, USN		DATE SIGNED 3/12/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-16-60	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph F. Birch		24a. REC'D BY REGISTRAR DATE MAR 15 '60	
ADDRESS 3034 M Street, N.W., Wash. D.C.		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

CERTIFICATE OF DEATH

2810

U.S.

WASHINGTON

DEPARTMENT OF HEALTH

WASHINGTON, D.C.

1910

DEPARTMENT (BUREAU)

1910

U.S. DEPARTMENT OF HEALTH

NOTES

(a)

Partially

6-11-10

Continued

Page

WASHINGTON, D.C.

U.S. NAVY

U.S. NAVY

Naval Hospital

Naval Hospital

Washington, D.C.

NAVY

NAVY

NAVY

U.S. Naval Hospital, Washington, D.C.

U.S. NAVY

NAVY

Washington, D.C.

NAVY

NAVY

U.S. Naval Hospital, Washington, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3480

CERTIFICATE OF DEATH

Reg. Dist. No.

03534

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash.</u> b. COUNTY <u>D.C.</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>14 10 Mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>OAKHAVEN CONVALESCENT HOME</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47x-3</u>	
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>HERTZLER</u> Last <u>MURRAY</u>		4. DATE OF DEATH Month <u>march</u> Day <u>1</u> Year <u>19 60</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 1, 1861</u>
9. AGE (In years last birthday) <u>98</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>PENNA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOHN HERTZLER</u> HERTZLER	
14. MOTHER'S MAIDEN NAME <u>FANNY ESKELMAN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) _____	
16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>ALBERT F. MURRAY (SON)</u> Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>794x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Intestinal Virus infection</u> cause (c) <u>Corylatic Illness</u> lying cause lost.			INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Aug 17, 1958</u> to <u>march 1, 1960</u> , that I last saw the deceased alive on <u>march 1, 1960</u> , and that death occurred at <u>1:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip E. Jones</u> M.D.		ADDRESS (Street, city or town, state) <u>918 Ellsworth Drive</u> DATE SIGNED <u>3-1-60</u>	
PHYSICIAN'S NAME (Type) <u>Philip E. Jones</u>		<u>Silver Spring Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	22b. DATE THEREOF <u>3-2-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CREMATORY</u>	22d. LOCATION (City, town, or county) (State) <u>SUTLAND, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gaudreault, Inc.</u> ADDRESS <u>1756 Pa. Ave. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 4 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO. 111

DATE OF DEATH

PLACE

CAUSE

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE

CAUSE

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE

CAUSE

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

RECEIVED

RECEIVED

RECEIVED

3611

CERTIFICATE OF DEATH

Reg. Dist. No.

03535

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 76 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS 1729 Dublin Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jack Middle David Last Neff				4. DATE OF DEATH Month March Day 20 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 15, 1918	
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months 42 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant				10b. KIND OF BUSINESS OR INDUSTRY Department Store		11. BIRTHPLACE (State or foreign country) District of Columbia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Harry Neff				14. MOTHER'S MAIDEN NAME Fannie Blum			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 578-10-4139			
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Widely metastatic malignant melanoma 190.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from January 4 , 19 60 , to March 20 , 19 60 , that I last saw the deceased alive on March 20 , 19 60 , and that death occurred at 8:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center Bethesda 14, Maryland DATE SIGNED 3/21/60 ACTUAL SIGNATURE Richard C. Mechanic M.D. The Clinical Center PHYSICIAN'S NAME (Type) RICHARD C. MECHANIC, M. D. National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar 22, 1960		22c. NAME OF CEMETERY OR CREMATORY Nat'l. Mem. Park		22d. LOCATION (City, town, or county) (State) Falls Church, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Herman Goldberg - Goldberg 4217 9th St. N.W.				24a. REC'D BY REGISTRAR MAR 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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8611

Montgomery

Montgomery

Montgomery

10 days

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The Clinical Center, Bethesda, Md.

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February 12, 1915

White

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Department of Health

Department of Health

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The Clinical Center

February 12, 1915

2 years

White

The Clinical Center
National Institute of Health
Bethesda, Md.

February 12, 1915

White

White

White

February 12, 1915

1 FOR STATE HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 3446 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05536

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
c. LENGTH OF STAY IN lb <u>DOA</u>				d. STREET ADDRESS <u>C 121, Norwood Road</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montg. Co. Gen. Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Thomas Francis Nelson, Jr.</u>				4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 11/60</u>	
9. AGE (In years last birthday) yrs. <u>5</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u>		IF UNDER 24 HRS. Hours <u>5</u> Min. <u>5</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Thomas Francis Nelson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Catherine Johnson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT <u>Hospital Records, Olney, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumo-pneumonia</u> <u>763.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3 days</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				DATE SIGNED <u>3-16-60</u>			
				Address (Street, city, town, or county) <u>Gaithersburg, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/19/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rocky Hill</u>		22d. LOCATION (City, town, or country) (State) <u>Clarkburg, Md.</u>	
23. FUNERAL DIRECTOR <u>Robert L. Dunode</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 22 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>			

VS. A15ME
5M 7/59

2073181XV4

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THIS CERTIFICATE IS TO BE FILLED OUT BY THE MEDICAL EXAMINER WHO HAS EXAMINED THE BODY OF THE DECEASED PERSON, AND IS TO BE FILED IN THE OFFICE OF THE MEDICAL EXAMINER, AND A COPY OF IT IS TO BE FURNISHED TO THE CORoner OF THE COUNTY IN WHICH THE DECEASED PERSON RESIDED.

1

1

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3481
CERTIFICATE OF DEATH

03537

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Montgomery Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>33 West Notley Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Baby Boy</u> First Middle Last <u>Newcomb.</u>				4. DATE OF DEATH Month <u>3</u> Day <u>13</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/12/60</u>	
9. AGE (In years last birthday) <u>14</u>		10. IF UNDER 1 YEAR Months <u>14</u> Days <u>16</u>		11. IF UNDER 24 HRS. Hours <u>14</u> Min. <u>16</u>		12. CITIZEN OF WHAT COUNTRY? <u>Maryland</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>James Edward Newcomb</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Gayle Renfro</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>James Edward Newcomb 33 West Notley Rd., S.S.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>776x</u> IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>14 Hr. 16</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>5:56 March 12 1960</u> to <u>March 13 1960</u> , that (I) (we) last saw the deceased alive on <u>March 13 1960</u> , and that death occurred at <u>8:26 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Winston E. Cochran M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>March 29</u>	
22c. PHYSICIAN'S NAME (Type) <u>Winston Cochran, M.D.</u>				22d. ADDRESS <u>927 Pershing Drive, S.S., Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>March 15, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium & Hospital, Takoma Park Md.</u>		23d. LOCATION (City, town, or county) _____ (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M.D. Wash. San. & Hospital</u>				ADDRESS _____		25a. REC'D BY REGISTRAR DATE <u>MAR 30 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hare</u>	

VR A15 (4)
15M 9/59
Mar 4/60

2075233XV2

STATE OF NEW YORK
OFFICE OF THE COMPTROLLER

John D. ...

Notary Public

Notary Public

Notary Public

Notary Public

Notary Public

Notary Public

Notary Public

Notary Public

Notary Public

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3612

CERTIFICATE OF DEATH

Reg. Dist. No.

03538

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1023 Potomac Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				83X-3			
3. NAME OF DECEASED (Type or print) First Thomas Middle Frederick Last Nissen				4. DATE OF DEATH Month March Day 17 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 24, 1958	
9. AGE (In years lost birthday) yrs. 1		IF UNDER 1 YEAR Months 1 Days 17 Hours 17 Min.		IF UNDER 24 HRS. Months 1 Days 17 Hours 17 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Spencer T. Nissen				14. MOTHER'S MAIDEN NAME Josephine Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Post exploratory thoracotomy 754.5 DUE TO Cyanotic congenital heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (transposition, single ventricle) DUE TO (c) 14 months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 23 hours							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.							
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 6 , 19 60 , to March 17 , 19 60 , that I last saw the deceased alive on March 17 , 19 60 , and that death occurred at 9:55A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3/17/60 ACTUAL SIGNATURE Roland Folse PHYSICIAN'S NAME (Type) Roland Folse, M.D. National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF March 19, 1960							
22c. NAME OF CEMETERY OR CREMATORY Mount Comfort							
22d. LOCATION (City, town, or county) (State) Fairfax County, Virginia							
23. FUNERAL DIRECTOR'S SIGNATURE W. Barclay Mount ADDRESS Cunningham Funeral Home, Inc. Cameron & Alfred Sts., Alex. Va.							
24a. REC'D BY REGISTRAR MAR 21 '60							
24b. REGISTRAR'S SIGNATURE Arthur S. Hume							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

03539

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY Madison			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 115 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS -----			
3. NAME OF DECEASED (Type or print) First Nat Middle Smith Last Norfleet				4. DATE OF DEATH Month March Day 21 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 24, 1937		9. AGE (In years last birthday) 23 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nat Norfleet				14. MOTHER'S MAIDEN NAME Rachael Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 264-48-8864		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage, left frontal lobe DUE TO 204.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Myelogenous leukemia DUE TO (c) Aspergillosis, disseminated							INTERVAL BETWEEN ONSET AND DEATH 4 months unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 27, 1959 to March 21, 1960 , that I last saw the deceased alive on March 21, 1960 , and that death occurred at 6:45 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Lawrence A. Gaydos		M.D. The Clinical Center		ADDRESS (Street, city or town, state) National Institutes of Health Bethesda 14, Maryland		DATE SIGNED 3/21/60	
PHYSICIAN'S NAME (Type) Lawrence A. Gaydos, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Tran		22b. DATE THEREOF 3/22/60		22c. NAME OF CEMETERY OR CREMATORY Oak Ridge Cemetery		22d. LOCATION (City, town, or county) (State) Madison, Florida	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR MAR 28 1960	
						24b. REGISTRAR'S SIGNATURE Arthur J. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

• The Clinical Center

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23

Personal history, present illness

06/07/2018 12:33

e. the novel

Lawrence A. Sanders, Jr.

3614

CERTIFICATE OF DEATH

Reg. Dist. No. 03540

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Fairway Hills	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 6208 Crathie Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alice Middle Eileen Last Nunley		4. DATE OF DEATH Month March Day 7 Year 19 60					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1920		9. AGE (In years last birthday) 39 yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) News Reporter		10b. KIND OF BUSINESS OR INDUSTRY Journalism		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Alfred Appleton				14. MOTHER'S MAIDEN NAME Eileen Donahue			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unascertainable		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive hemorrhage into lungs DUE TO 170x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of breast DUE TO (c) 3 years						INTERVAL BETWEEN ONSET AND DEATH hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 6 , 19 60 , to March 7 , 19 60 that I last saw the deceased alive on March 7 , 19 60 , and that death occurred at 4:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3/8/60 ACTUAL SIGNATURE Howard Schwartz M.D. The Clinical Center PHYSICIAN'S NAME (Type) HOWARD SCHWARTZ, M. D. National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL (CREMATION, REMOVAL) (Specify) 3/9/60		22b. DATE THEREOF 3/9/60		22c. NAME OF CEMETERY OR CREMATORY Lee's		22d. LOCATION (City, town, or county) (State) Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE William Lee 300-4 St NE				24a. REC'D BY REGISTRAR DATE MAR 10 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Knap	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK

114

IN SENATE
January 11, 1900
REPORT OF THE
COMMISSIONERS OF THE
DEPARTMENT OF
CORRECTIONS
FOR THE YEAR
1899

ALBANY:
J. B. LIPPINCOTT & CO.,
PRINTERS,
1899.

THE DEPARTMENT OF
CORRECTIONS
ALBANY, N. Y.,
JANUARY 11, 1900.

REPORT OF THE
COMMISSIONERS OF THE
DEPARTMENT OF
CORRECTIONS
FOR THE YEAR
1899

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3615

CERTIFICATE OF DEATH

03541

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 5 hrs. 20min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				d. STREET ADDRESS Hillcrest Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Kathleen Middle Mary Last Odum				4. DATE OF DEATH Month March Day 6 Year 19 60			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1947		9. AGE (In years last birthday) 13 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Schoolgirl		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bernard Paul Odum				14. MOTHER'S MAIDEN NAME Doris Mayhew			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Odum Address Doris Mayhew, Hillcrest Ave., Olney, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490X DUE TO Lobar Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Palsy						INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 6, 1960 to March 6, 1960 , that (I) (we) last saw the deceased alive on March 6, 1960 , and that death occurred at 6:00 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Richard A. Yates M.D.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/6/60	
22c. PHYSICIAN'S NAME (Type) Richard A. Yates, M.D.				22d. ADDRESS Olney, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/8/60		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		23d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, Inc.				ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR DATE MAR 9 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kline			

14541

CERTIFICATE OF DEATH

14541

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

1
 3616
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

03542

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>10 hr 20 min</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>		d. STREET ADDRESS <u>Box 62</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Ernest</u> Last <u>Offord</u>		4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 7, 1920</u>
9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Animal caretaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Tolbert Offord</u>		14. MOTHER'S MAIDEN NAME <u>Ada Virginia Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Gladys Virginia Offord</u>		Address <u>Sandy Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fatty metamorphosis of liver</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>10/25/60</u> to <u>3/13/60</u> , that (I) (we) last saw the deceased alive on <u>3/12/60</u> , and that death occurred at <u>6:40a</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>3/13/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. H. Ligon M. D.</u>		22d. ADDRESS <u>Sandy Spring, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/16/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial,</u>		23d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Swander</u>		ADDRESS <u>Rockville, Md.</u>	
25a. REC'D BY REGISTRAR DATE <u>MAR 17 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

STATE OF TEXAS
COUNTY OF DALLAS

3038

Blank legal form with faint lines and text, including a circular stamp on the right side.

1 FOR STATE HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3617 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05543

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RFD #1 Derwood				c. LENGTH OF STAY IN 1b 3 wks.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Russells Nursing Home				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Comas			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Nettie Lumar Onley				4. DATE OF DEATH Month Mar. Day 30 Year 1960			
5. SEX female		6. COLOR OR RACE col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/16/1895	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 65 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework				10b. KIND OF BUSINESS OR INDUSTRY MD.		11. BIRTHPLACE (State or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME George Hayes				14. MOTHER'S MAIDEN NAME Edmonia Fields			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)			
17. INFORMANT Eleanor Ambush, Comas Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Disease 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Generalized arterio sclerosis (a), stating the underlying cause last. } DUE TO (c) Diabetis mellitis						INTERVAL BETWEEN ONSET AND DEATH 2 days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 3/31/60			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/2/60		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion,		22d. LOCATION (City, town, or country) (State) Barnesville, Md.	
23. FUNERAL DIRECTOR Robert L. Sando ADDRESS Rockville, Md.				24a. REC'D BY REGISTRAR DATE APR 4 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3511

03544

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b 16 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3615 Calvend Lane				d. STREET ADDRESS 3615 Calvend Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANCES First OVINGTON Middle Last				4. DATE OF DEATH Month MARCH Day 5 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 14, 1878	
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 2 Days 21		11. IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Iowa	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME Johnathan T. Spry				14. MOTHER'S MAIDEN NAME Anna M. Taggart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Frances S. Ovington-daughter-same 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of Pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----							INTERVAL BETWEEN ONSET AND DEATH 3 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from February 1, 1960 , to March 5, 1960 , that (I) (we) last saw the deceased alive on March 5, 1960 and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE Thomas S. Sappington				22b. DATE SIGNED March 5, 1960		22c. PHYSICIAN'S NAME (Type) THOMAS S. SAPPINGTON	
22d. ADDRESS 1025 CONNETTICUT AVE NW, WASH, D.C.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/9/60		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE MAR 11 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Frank			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

Reg. Dist. No.

03545

3618

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>26 Rockville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Boy</i> Middle <i>Painter</i> Last <i>Painter</i>		4. DATE OF DEATH Month <i>3</i> Day <i>27</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 25, 1960</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) <i>2 days</i>
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Douglas F. Painter</i>		14. MOTHER'S MAIDEN NAME <i>Barbara Williams</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Informant Address Father Douglas F. Painter</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anoxia</i> 762.0 DUE TO (b) <i>Pulmonary atelectasis</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Mar 25, 1960</i> to <i>Mar. 27, 1960</i> , that I last saw the deceased alive on <i>Mar. 27, 1960</i> , and that death occurred at <i>5:50 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Harold M. Hobart</i>		ADDRESS (Street, city or town, state) <i>5402 Conn. Ave. D.C.</i>	
PHYSICIAN'S NAME (Type) <i>HAROLD M. HOBART</i>		DATE <i>5/27/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/31/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Derwood Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Derwood, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		ADDRESS <i>Bethesda, Maryland</i>	
24a. REC'D BY REGISTRAR <i>DATE MAR 31 '80</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

1

PAGE 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Pages 1 and 2 should be filled with information retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 2/58

2074233 XV4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

3447
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03546

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 56	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		d. STREET ADDRESS 12,202 GRANDVIEW AVENUE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12,202 GRANDVIEW AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle U. Last PARKER		4. DATE OF DEATH Month MARCH Day 12 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/22/86
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 7 Days 12 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS H. PARKER		14. MOTHER'S MAIDEN NAME MARIA V. JONES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 578-18-0536	
17. INFORMANT Mrs. Maud S. Parker, 12,202 Grandview Ave. Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Pulmonary Edema 163 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Cancer of Lung DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None INTERVAL BETWEEN ONSET AND DEATH March 11 - March 12, 1960 January 1959 - 2 1/2 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 1959 to March 12 1960 , that (I) (we) last saw the deceased alive on March 11 1960 , and that death occurred at 8:58 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Michael R. Dobridge		22b. DATE SIGNED March 12, 1960	
22c. PHYSICIAN'S NAME (Type) MICHAEL R. DOBRIDGE		22d. ADDRESS 10620 Georgia Ave. Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/16/60	
23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond W. Fisher		25a. REC'D BY REGISTRAR MAR 15 '60	
ADDRESS SILVER SPRING, MD.		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

CERTIFICATE OF DEATH

100-100000

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3482

CERTIFICATE OF DEATH

03547

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>9 yr</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7625 Carroll Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sarah</u> First <u>Lanning</u> Middle <u>Parsons</u> Last		4. DATE OF DEATH <u>March 4</u> Month <u>1960</u> Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 17, 1876</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Stanley</u>		14. MOTHER'S MAIDEN NAME <u>Ada Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>E. Jones</u> Address <u>7625 Carroll Ave Tak Pk</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Peritonitis</u> <u>153.0</u> DUE TO (b) <u>Adenocarcinoma Cecum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Unknown</u>			INTERVAL BETWEEN ONSET AND DEATH <u>11 da</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture Left Femur</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-22</u> , 19 <u>60</u> to <u>3-4</u> , 19 <u>60</u> , that I lost s/he the deceased alive on <u>March 3</u> , 19 <u>60</u> , and that death occurred at <u>2:30 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Roy B Parsons Jr</u> M.D.		ADDRESS (Street, city or town, state) <u>804 Northwest Dr Silver Spring Md</u>	
PHYSICIAN'S NAME (Type) <u>Roy B Parsons Jr</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Mar 8, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>254 Carroll St. NW O.G.</u>		22d. LOCATION (City, town, or county) (State) <u>SALEM, SALEM Co. W. V.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u> ADDRESS <u>254 Carroll St. NW O.G.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 8 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HO...AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3485

NAME

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

USUAL RESIDENCE

DATE OF INTERVIEW

INTERVIEWER

DATE OF ENTRY

ENTRY NUMBER

DATE OF FILING

FILING NUMBER

DATE OF REGISTRATION

REGISTRATION NUMBER

DATE OF ISSUANCE

ISSUANCE NUMBER

DATE OF CANCELLATION

CANCELLATION NUMBER

DATE OF REVISION

REVISION NUMBER

DATE OF AMENDMENT

AMENDMENT NUMBER

DATE OF CORRECTION

CORRECTION NUMBER

DATE OF FINAL REVIEW

FINAL REVIEW NUMBER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3619

CERTIFICATE OF DEATH

Reg. Dist. No.

03548

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 26 Rockville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sharon Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ambrose Middle E Last Parton				4. DATE OF DEATH Month 3 Day 25 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/10/1888	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 9 Days 15		IF UNDER 24 HRS. Hours 15 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-mechanic				10b. KIND OF BUSINESS OR INDUSTRY Garage		11. BIRTHPLACE (State or foreign country) Kentucky	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME William Parton				14. MOTHER'S MAIDEN NAME Nancy Parton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) WW yes WW 1				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Grace Parton-wife-same as 2d	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 526 X DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia DUE TO Pneumonia (c) Pneumonia				INTERVAL BETWEEN ONSET AND DEATH 1 wk. 4 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis - Senility.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 1960				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10/25 , 19 59 , to 3/25 , 19 60 , that I last saw the deceased alive on 3/18 , 19 60 , and that death occurred at 11:15 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE C. H. Hinton M.D.				ADDRESS (Street, city or town, state) DATE SIGNED Sandy Spring Md. 3/25/60			
PHYSICIAN'S NAME (Type) C. H. Hinton M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/29/60		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR 30 60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hous			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
JAMES H. HARRIS		MALE		45		JAN 15 1950	
RESIDENCE		CITY		COUNTY		STATE	
1234 E. MAIN ST.		BALTIMORE		BALTIMORE		MD	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
LABORER		HEART DISEASE		NATURAL		HOME	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE	
JAN 15 1905		BALTIMORE, MD		HIGH SCHOOL		MARRIED	
MOTHER'S NAME		FATHER'S NAME		RELIGION		RACE	
JANE HARRIS		JOHN HARRIS		METHODIST		WHITE	
PREVIOUS ILLNESS		TREATMENT		HISTORY		FAMILY HISTORY	
NONE		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]	
DATE		TIME		PLACE		CITY	
JAN 15 1950		10:00 AM		HOME		BALTIMORE	

12

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 12

3448

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 18 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 723 RICHMOND AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SARA Middle JANE Last PEDDICORD		4. DATE OF DEATH Month MARCH Day 1 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1873
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE NICHOLSON		14. MOTHER'S MAIDEN NAME ELIZA MUSGROVE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mr. Harold Peddicord, 723 Richmond Ave. Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1950 to 3/1 , 19 60 , that I last saw the deceased alive on 3/1 , 19 60 , and that death occurred at 6:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 906 Colesville Rd. Silver Spring, Md. DATE SIGNED 3/4/60			
ACTUAL SIGNATURE William D. Aud M.D.		PHYSICIAN'S NAME (Type) WILLIAM D. AUD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3/4/60	22c. NAME OF CEMETERY OR CREMATORY COLESVILLE CEMETERY	22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. <i>Raymond A. Jones</i>		24a. REC'D BY REGISTRAR MAR 4 '60	
24b. REGISTRAR'S SIGNATURE <i>Raymond A. Jones</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[illegible]

6

1000

2652

2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3483

CERTIFICATE OF DEATH

03550

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. Har. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurens Park</u>			c. LENGTH OF STAY IN 1b <u>1 hr 10 min</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover Hills</u> <u>1637-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington San. & Hospital</u>				d. STREET ADDRESS <u>4404 71st Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clarence Everett Pendleton</u>				4. DATE OF DEATH Month <u>3</u> Day <u>16</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-25-82</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>16</u> Hours <u>19</u> Min. <u>60</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate Salesman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>
13. FATHER'S NAME <u>Henry Clay Pendleton</u>				14. MOTHER'S MAIDEN NAME <u>Helen Coons</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-05-3795</u>		17. INFORMANT <u>Patient's Chart - Wash. San. & Hosp.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>March 16</u> , 19 <u>60</u> , and that death occurred at <u>9:25</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward J. Richards</u> M.D.				ADDRESS (Street, city or town, state) <u>10110 Georgia Ave. Silver Spring, Md.</u>		DATE SIGNED <u>3-16-60</u>	
PHYSICIAN'S NAME (Type) <u>Edward J. Richards</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>3/19/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Nune Co. Wash. G. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kump</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03551

3500

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 58 Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 127 Grafton Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMILE Middle A Last PESSAGNO		4. DATE OF DEATH Month March Day 23 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/21/1896
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 3 Days 2	IF UNDER 24 HRS. Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Builder	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Joseph P. Pessagno		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1 578-34-4030	
17. INFORMANT Elsie Pessagno, Wife, same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion (c) Right Bundle Branch Block DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Pancreatitis and Adrenal Insufficiency			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 20 min 10 hrs. 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Decatur, 1950 , to 3/23 , 19 60 , that I last saw the deceased alive on 3/23 , 19 60 , and that death occurred at 3:30 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank Y. Jagers, Jr		M.D. 5707 Wisconsin Ave	
PHYSICIAN'S NAME (Type) Frank Y. Jagers, Jr		DATE SIGNED 3/23/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 3/24/60	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		24a. REC'D BY REGISTRAR MAR 28 '60	
ADDRESS Bethesda, Maryland		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

CERTIFICATE OF DEATH

NAME OF DECEASED JOSEPH P. FORTENCO		SEX Male	
DATE OF BIRTH 1882-10-10		AGE 37 years	
PLACE OF BIRTH Italy		RACE White	
STREET 137 Camden Street		CITY Baltimore	
COUNTY Baltimore		STATE Maryland	
MARITAL STATUS Single		OCCUPATION Laborer	
CAUSE OF DEATH Heart Disease		MEDICAL HISTORY None	
DATE OF DEATH 1920-01-10		TIME OF DEATH 10:00 AM	
PLACE OF DEATH Home		SIGNATURE OF DECEASED (None)	
SIGNATURE OF PHYSICIAN J. P. Fortenco		SIGNATURE OF WITNESSES (None)	
REGISTERED Yes		INDEXED Yes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

3620

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03552

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 84 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oak Grove 62X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS - - - - -		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Richard Middle Leo Last PIPER		4. DATE OF DEATH Month March Day 22 Year 19 60					
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-15-14		9. AGE (In years lost birthday) 45 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hugh PIPER				14. MOTHER'S MAIDEN NAME Allie SANDIFER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 1941 to 1960		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 197.9 DUE TO Anoxia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pleural effusion and metastatic tumor to lungs 5 mos. (c) Left retroperitoneal Synovial Sarcoma 5 mos plus						INTERVAL BETWEEN ONSET AND DEATH 1 1/2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from December 29 1959, to March 22, 19 60, that (I) (we) last saw the deceased alive on March 21, 19 60, and that death occurred at 2:50 AM, from the causes and on the date stated above.							
22a. SIGNATURE R. T. Brooks				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-22-60	
22c. PHYSICIAN'S NAME (Type) R. T. BROOKS, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 3-23-60		23c. NAME OF CEMETERY OR CREMATORY Lees Summit		23d. LOCATION (City, town, or county) (State) Lees Summit Missouri	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers, 1400 Chapin St. NW, Washington, D.				25a. REC'D BY REGISTRAR MAR 24 60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraske	

CERTIFICATE OF DEATH

38820

DATE OF DEATH

1940

(1940)

1. NAME OF DECEASED

1940

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3449

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>56 Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8817 Glenville Road</i>		d. STREET ADDRESS <i>8817 Glenville Road</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>STEPHANIE PIUREK PLOCHARCZYK</i>		4. DATE OF DEATH Month Day Year <i>March 17 1960</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 29, 1920</i>
9. AGE (In years last birthday) <i>39</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Internal Revenue</i>	
11. BIRTHPLACE (State or foreign country) <i>Connecticut</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Piurek</i>		14. MOTHER'S MAIDEN NAME <i>Sophie Janda</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>048093849</i>	
17. INFORMANT <i>Walter Plocharczyk</i>		Address <i>8817 Glenville Rd. Silver Spring, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized carcinomatosis</i> <i>175.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Ovarian carcinoma</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>18 months</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>May 1957</i> , to <i>March 17, 1960</i> , that I last saw the deceased alive on <i>March 17, 1960</i> , and that death occurred at <i>8:35 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Eino Magi</i>		DATE SIGNED <i>3/17/60</i>	
PHYSICIAN'S NAME (Type) <i>EINO MAGI</i>		ADDRESS (Street, city or town, state) <i>918 Univ. Blvd. E. Silver Spring, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>TRANS. & BURIAL</i>	22b. DATE THEREOF <i>3/19/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>MT. ST. BENEDICT CEMETERY</i>	22d. LOCATION (City, town, or county) (State) <i>HARTFORD, CONN.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond A. Jirka</i>		24a. REC'D BY REGISTRAR <i>DATE MAR 18 '60</i>	24b. REGISTRAR'S SIGNATURE <i>C. Long & Kunk</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3486
CERTIFICATE OF DEATH

03554

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <i>MD</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shows Park -</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wash</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wash San & Hosp</i>		d. STREET ADDRESS <i>2211 - 42 NW</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Flourens</i> Middle <i>West</i> Last <i>Prentice</i>		4. DATE OF DEATH Month <i>3</i> Day <i>13</i> Year <i>1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 14 - 1877</i>
9. AGE (In years last birthday) <i>82</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>St. C.</i>	
11. BIRTHPLACE (State or foreign country) <i>St. C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Charles Craven</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Altman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>Wash San & Hosp records</i>	
17. INFORMANT Address <i>Wash San & Hosp records</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Cerebral Infarct</i> <i>332x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Early Necrosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <i>3/4/60</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>2/24/1946</i> to <i>3/13/1960</i> that (I) (we) last saw the deceased alive on <i>3/13/1960</i> , and that death occurred at <i>6:00</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Howard T. Morse</i>		22b. DATE SIGNED <i>3/13/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Howard T. Morse</i>		22d. ADDRESS <i>2030 Carroll Ave. Takoma Park, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>March 17, 1960</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Baptist Church Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Chicamagua, Georgia</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>J Arthur Walters</i>		25a. REC'D BY REGISTRAR <i>MAR 16 '60</i>	
ADDRESS <i>254 Carroll St. NW</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. House</i>	

CERTIFICATE OF DEATH

X-501



3621

CERTIFICATE OF DEATH

03555

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville		c. LENGTH OF STAY IN lb 3 Weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Matthews Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle CARVE Last PRICE		4. DATE OF DEATH Month March Day 17 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 Nov 1879
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm Owner	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George W. Price	
14. MOTHER'S MAIDEN NAME Eunie Day		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 217-36-6200		INFORMANT Dr. Warren Price, Kensington, Md.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X Artemia, d. DUE TO (b) Atherosclerotic Renal Disease DUE TO (c) Generalized Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 years 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
19a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	19b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	19c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	19d. (City or town) (County) (State)
21. I certify that I attended the deceased from 17 March, 19 58 , to 17 March, 19 60 , that I last saw the deceased alive on 16 March, 19 60 , and that death occurred at 6:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon M. Smith		DATE SIGNED 17 March 60	
PHYSICIAN'S NAME (Type) Gordon M. Smith, M. D.		ADDRESS (Street, city or town, state) Barnesville, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-19-60	22c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery	22d. LOCATION (City, town, or county) (State) Hyattstown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W. L. Burdette, Hyattstown, Maryland		24a. REC'D BY REGISTRAR DATE MAR 21 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hunt	

VS A1S (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3851

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MALE

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George F. Price

100-1000

217-3-02-0 Mr. Nathan Price, Annapolis, Md.

Attest: I, the undersigned, being a duly qualified physician, do hereby certify that the above is a true and correct copy of the original certificate of death filed in my office on the 10th day of March, 1910.

Witness my hand and seal this 10th day of March, 1910.
J. B. Bayne, M.D., Registrar
J. B. Bayne, M.D., Registrar

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3622 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 3, 17 Film G260 4-4-60 et

Reg. Dist. No.

03556

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	c. LENGTH OF STAY IN 1b <u>DOA</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>57 Bethesda 14</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>18815 Seven Locks Rd.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Carl</u> First <u>George</u> Middle <u>Qualles</u>		4. DATE OF DEATH <u>3/28</u> Month <u>3</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-7-1901</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handyman</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Qualles</u>	
14. MOTHER'S MAIDEN NAME <u>Minerva Tally</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>529-163779</u>		17. INFORMANT <u>Mattie Qualles (wife)</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>sudden</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Brochant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROCHANT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-31-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL</u>
22d. LOCATION (City, town, or county) <u>FT MYER</u>		(State) <u>Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers G</u>		ADDRESS <u>3072-M-54 N.W.</u>	
24a. REC'D BY REGISTRAR <u>DATE MAR 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

3450

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 30 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8001 WOODBURY DRIVE		e. STREET ADDRESS 8001 WOODBURY DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EARL		First D		Middle REID	
4. DATE OF DEATH MARCH		Month 8		Day 19	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 2/14/85		9. AGE (In years last birthday) 75		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ichthyologist		10b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T.		11. BIRTHPLACE (State or foreign country) MISSISSIPPI	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ELMER REID		14. MOTHER'S MAIDEN NAME JENNIE PASSENGER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. Grace E. Reid, 8001 Woodbury Dr. Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO myocardial failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) coronary insufficiency (c) generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 week 4 yrs - 10 yrs -		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) X-Ray evidence Carcinoma of lung probably metastatic -		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 8005 Woodbury Drive, S.S.Md.	
20f. (City or town) PRINCE GEO. COUNTY, MD.		20g. (County) PRINCE GEO. COUNTY, MD.		20h. (State) MD.	
21. I certify that (I) (this hospital) attended the deceased from 1-2-1944 to 3-8-1960 , that (I) (we) last saw the deceased alive on 3-8-1960 , and that death occurred at 4:50 P.M. from the causes and on the date stated above.		22a. SIGNATURE N.C. Shoemaker, M.D.		22b. DATE SIGNED MAR 10 1960	
22c. PHYSICIAN'S NAME (Type) N.C. Shoemaker, M.D.		22d. ADDRESS 8005 Woodbury Drive, S.S.Md.		22e. REC'D BY REGISTRAR Arthur S. Kraus	
23a. BURIAL, CREMATION, or other disposal (Specify) BURIAL		23b. DATE THEREOF 3/11/60		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY	
23d. LOCATION (City, town, or county) PRINCE GEO. COUNTY, MD.		23e. (State) MD.		23f. FUNERAL HOME'S SIGNATURE Warner E. Pumphrey, Inc., Silver Spring, Md.	
23g. ADDRESS Warner E. Pumphrey, Inc., Silver Spring, Md.		23h. REC'D BY REGISTRAR MAR 10 1960		23i. REGISTRAR'S SIGNATURE Arthur S. Kraus	

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

240

ALBANY, N. Y.
JANUARY 1, 1900
JAMES H. HARRIS
MARRIED

ALBANY, N. Y.

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CERTIFICATE OF DEATH

Reg. Dist. No.

Birth Weight

2 lbs.

3622

1. PLACE OF DEATH

a. COUNTY

MONTGOMERY

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

o. STATE

b. COUNTY

MARYLAND MONTGOMERY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

BETHESDA

c. LENGTH OF STAY IN 1b

11 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

26 ROCKVILLE

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

SUBURBAN HOSPITAL

d. STREET ADDRESS

1 705 EDMONSTON AVE

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First

Middle

Last

CONNIE

MARIE

RICE

4. DATE OF DEATH

Month

Day

Year

MARCH

10

1960

5. SEX

FEMALE

6. COLOR OR RACE

WHITE

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

FEBRUARY 29 1960

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10

13

10

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

CARL JULIUS RICE

14. MOTHER'S MAIDEN NAME

LOIS MERRY LANCASTER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

INFORMANT

Address

MOTHER

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

770.6

DUE TO

convulsions

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b)

DUE TO

Hemicterus

(c)

DUE TO

Prematurity

INTERVAL BETWEEN ONSET AND DEATH

10 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Hyperbilirubinemia

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.

20d. INJURY OCCURRED While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 2/29, 1960, to 3/10, 1960, that I last saw the deceased alive on 3/10, 1960, and that death occurred at 7:00 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE

Richard M. Auld

M.D.

ADDRESS (Street, city or town, state)

809 View Mill Rd. Rockville, Md.

DATE SIGNED

3/10/60

PHYSICIAN'S NAME (Type)

Richard M. Auld

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

3/12/60

22c. NAME OF CEMETERY OR CREMATORY

Rockville

22d. LOCATION (City, town, or county)

Rockville, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Byron Wheeler - Rockville, Md.

24a. REC'D BY REGISTRAR

DATE MAR 14 '60

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus

207418 1XV0

CERTIFICATE OF DEATH

3822



3624

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 18 Jib Green S.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Michael John RICHARDS		4. DATE OF DEATH Month Day Year March 14 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-17-53
9. AGE (In years lost-birthday) yrs. 6		10. IF UNDER 1 YEAR Months Days Hours Min. 4 7 X - 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Elbert RICHARDS		14. MOTHER'S MAIDEN NAME Jean Willa TUTTLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) John E. Richards		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 510.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Post-operative Tonsillectomy + Adenoidectomy DUE TO (c) 12 hrs		INTERVAL BETWEEN ONSET AND DEATH 4 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 14 March 1960 to 14 March 1960 , that I last saw the deceased alive on 14 March 1960 , and that death occurred at 11:07 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE George W. Taylor Jr.		M.D. U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) G.W. TAYLOR CDR MC USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-17-60	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumpfrey		24a. REC'D BY REGISTRAR DATE MAR 17 '60	
ADDRESS 7557 Wisconsin Ave. Bethesda Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Director of Columbia

Washington

12 21 1953

RICHARD

12 21 1953

North Carolina

John White Turner

(President, John B. Richardson

12 21 1953

12 21 1953

12 21 1953

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

Washington, D.C.

Washington, D.C.

12 21 1953

12 21 1953

U.S. Naval Hospital, Bethesda, Md.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03560

3451

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Seymour Nursing Home				d. STREET ADDRESS 12800 ELMORA STREET			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ALMA Middle E. Last ROBERTS				4. DATE OF DEATH Month MARCH Day 12 Year 19 60			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/1/81		9. AGE (In years lost birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Clerk		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PETER BIERBAUER				14. MOTHER'S MAIDEN NAME BARBARA RICKEMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. J. Benjamin Williams, 2800 Elnora St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Essential Hypertension DUE TO (c) Cerebral Arterio Sclerosis							INTERVAL BETWEEN ONSET AND DEATH 1 day years 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arterio Sclerosis							19. (WAS AUTOPSY PERFORMED?) YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1, 1960 to March 12, 1960 that (I) (we) lost the deceased alive on March 12, 1960 , and that death occurred at 8 P M , from the causes and on the date stated above.							
22a. SIGNATURE John J. Curry MD				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/12/60	
22c. PHYSICIAN'S NAME (Type) JOHN J. CURRY				22d. ADDRESS 10620 Georgia Ave Silver Spring			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/15/60		23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		23d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond E. J. J. J.				ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR DATE MAR 15 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3625

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03561

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b Bethesda		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4610 West Virginia Avenue			d. STREET ADDRESS 4610 West Virginia Ave		
3. NAME OF DECEASED (Type or print) Catherine Edith Robertson			4. DATE OF DEATH Month March Day 8 Year 19 60		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 24, 1883		9. AGE (In years last birthday) 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U S
13. FATHER'S NAME Charles H Campbell			14. MOTHER'S MAIDEN NAME Simpronia Bond		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Samuel Robertson-husband-same as 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 430.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/11/60		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	
22d. LOCATION (City, town, or county) Silver Spring, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR MAR 10 '60	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kears</i>					

MEDICAL CERTIFICATION

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If on duty, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED MARY ANN WHITE		SEX FEMALE	
AGE 45		DATE OF BIRTH JAN 15 1880	
PLACE OF BIRTH BALTIMORE, MARYLAND		OCCUPATION HOUSEWIFE	
MARITAL STATUS MARRIED		DATE OF MARRIAGE 1895	
NAME OF SPOUSE JOHN WHITE		OCCUPATION LABORER	
PLACE OF DEATH 1234 BALTIMORE ST., BALTIMORE, MARYLAND		DATE OF DEATH DEC 10 1925	
TIME OF DEATH 10:00 AM		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		SIGNATURE OF PHYSICIAN J. H. SMITH	
SIGNATURE OF MEDICAL EXAMINER W. H. JONES		OFFICIAL SEAL (Seal of the State Department of Health)	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4
TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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3626
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03562

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Connecticut		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 92 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New London		45x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital				d. STREET ADDRESS Maxson Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Charles		Middle Eric		Last SANDGREN	
4. DATE OF DEATH		Month March		Day 24		Year 19 60	
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-6-84	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Officer		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carl A. SANDGREN				14. MOTHER'S MAIDEN NAME Evelina PETERSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 1903-1946		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Congestive Heart Failure (b) Myocardial Infarction (c) Coronary artery atherosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia, right lung						INTERVAL BETWEEN ONSET AND DEATH 2 days 1 month	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) did not attended the deceased from Dec. 23 1959 to Mar. 24 1960, that (I) was last saw the deceased alive on March 23 1960, and that death occurred at 0435 from the causes and on the date stated above.							
22a. SIGNATURE Joseph E. Stitcher				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-24-60	
22c. PHYSICIAN'S NAME (Type) J. E. STITCHER, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-28-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE S. H. Hines Co., 2901 14th St., NW, Wash. D. C.				25a. REC'D BY REGISTRAR MAR 28 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CENTRAL OFFICE OF DEATH

353E



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VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3627

CERTIFICATE OF DEATH

Reg. Dist. No.

64754

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE South Carolina b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Route #4			
3. NAME OF DECEASED (Type or print) First Montez Middle Jerrell Last Sanford				4. DATE OF DEATH Month March Day 31 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 6, 1946	
9. AGE (In years last birthday) 13 yrs.		IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James C. Sanford				14. MOTHER'S MAIDEN NAME Pauline Coody			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Postoperative State DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Congenital Heart Disease DUE TO (c) Ventricular Septal Defect and Pulmonic Stenosis							INTERVAL BETWEEN ONSET AND DEATH 36 hours Birth Birth
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 20, 1960 to March 31, 1960 that I last saw the deceased alive on March 31, 1960 and that death occurred at 10:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE E. Kent Carney				ADDRESS (Street, city or town, state) The Clinical Center Bethesda 14, Maryland			
DATE SIGNED April 1, 1960							
PHYSICIAN'S NAME (Type) E. Kent Carney, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 4-1-60		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Grandview Cemetery		22d. LOCATION (City, town, or county) (State) Greenville County, So. Car.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR APR 7 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. K...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Death Certificate

Travelers Rest

11 days

House of

11 days

Sanford

Sanford

October 6, 1966

Georgia

Waco

Pauline Wood

Pauline Wood

The Clinical Center, National I, Maryland

None

Postoperative State

Continental Heart Service

Continental Heart Service

March 21, 60

March 20,

10:30p

The Clinical Center
National Institute of Health
Bethesda, Md.

Dr. J. Kent Carter, M.D.

Greenlife County, Md.

Greenlife County, Md.

Greenlife County, Md.

Greenlife County, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3501
CERTIFICATE OF DEATH

03563

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		MARYLAND c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 58 Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4700 Drummond Avenue		d. STREET ADDRESS 1 4700 Drummond Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HAROLD DEAN SCANTLIN		4. DATE OF DEATH Month March Day 22 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/1/1881	9. AGE (In years lost birthday) 78 yrs.	IF UNDER 1 YEAR Months 7 Days 21 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Tax Board		10b. KIND OF BUSINESS OR INDUSTRY Taxes		11. BIRTHPLACE (State or foreign country) Indiana	
12. CITIZEN OF WHAT COUNTRY? US					
13. FATHER'S NAME Thomas Scantlin			14. MOTHER'S MAIDEN NAME Jenny Dean		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Hoover-daughter-same as 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of sigmoid colon 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 					INTERVAL BETWEEN ONSET AND DEATH 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 19 59 to March 23, 19 60 , that (I) (we) lost the deceased alive on March 19, 19 60 , and that death occurred at 12 1/2 M, from the causes and on the date stated above.					
22a. SIGNATURE R. Stephen Hulburt		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/22/60	
22c. PHYSICIAN'S NAME (Type) R. Stephen Hulburt		22d. ADDRESS 3000 Dent Place, N.W., Washington, D.C.			
23a. BURIAL, CREMATION, REMOVAL (specify) Burial		23b. DATE THEREOF 3/25/60		23c. NAME OF CEMETERY OR CREMATORY Millersville Cemetery	
23d. LOCATION (City, town, or county) Millersville, Md.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE MAR 28 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus					

2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3485
CERTIFICATE OF DEATH

03564

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>			c. LENGTH OF STAY IN 1b <i>56 Silver Spring</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium</i>			d. STREET ADDRESS <i>11209 Noyes Drive</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Henry</i> Middle <i>Schirmer</i> Last			4. DATE OF DEATH Month <i>March</i> Day <i>25</i> Year <i>1960</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-7-85</i>		9. AGE (In years last birthday) <i>74</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Real Estate Dealer</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Henry Schirmer</i>			14. MOTHER'S MAIDEN NAME <i>Catherine Nagengast</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT <i>Chart</i> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>162.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <i>Bronchogenic carcinoma, left.</i> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>5 months</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Oct. 1958</i> to <i>25 March 1960</i> , that (I) (we) last saw the deceased alive on <i>25 March 1960</i> , and that death occurred at <i>9:30 P.</i> M, from the causes and on the date stated above.					
22a. SIGNATURE <i>Senach T. Humble</i>			22b. DATE SIGNED <i>25 March 60</i>		
22c. PHYSICIAN'S NAME (Type) <i>Dr S Kintle</i>			22d. ADDRESS <i>929 Pershing Drive, Silver Spring.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>3/29/60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glenwood Cemetery</i>	
23d. LOCATION (City, town, or county)		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <i>The 24 Hours Co. 2901-1828 7.20</i>			25a. REC'D BY REGISTRAR <i>MAR 28 60</i>		
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Amos</i>					

100-443887-100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3486

CERTIFICATE OF DEATH

03565

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Jan. + Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>GOLDIE</u> First Middle Last		4. DATE OF DEATH <u>MARCH</u> Month Day Year <u>30</u> <u>1960</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-4-27</u>		9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store - Hardware</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hardware business</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Abraham Kessler</u>			
14. MOTHER'S MAIDEN NAME <u>Ida Seigel</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>578-48-6910A</u>				17. INFORMANT <u>Chart record</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RUPTURED ABDOMINAL ANEURYSM Acute</u> <u>451X</u> DUE TO <u>DISSECTING</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROSIS</u> DUE TO <u>SENILITY</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>(1) CONGESTIVE HEART FAILURE (2) BILATERAL PLEURAL EFFU.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>SIOWS.</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>AUG</u> 19 <u>59</u> , to <u>MARCH 30</u> 19 <u>60</u> , that I last saw the deceased alive on <u>3-29</u> 19 <u>60</u> , and that death occurred at <u>9:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8829 FLOWER AVE</u> DATE SIGNED ACTUAL SIGNATURE <u>Samuel A. Hillman</u> M.D. <u>SILVER SPRING Md.</u> PHYSICIAN'S NAME (Type) <u>SAMUEL A. HILLMAN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/31/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NATH. CAP. HEBREW CON</u>		22d. LOCATION (City, town, or county) (State) <u>DENNINGS, DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sheep Funeral Home</u> ADDRESS <u>4217-9th Ave</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 31 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Kenna</u>	

the authors did not attempt to control for the possibility that the observed association between the two variables might be due to a third variable. For example, the observed association might be due to a third variable, such as the presence of a tumor, which could cause both the observed association and the observed association.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

3497

1

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03566

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b since Sept. <i>565 Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wash. San + Hosp.</i>		d. STREET ADDRESS <i>1912 Carmody</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>James Elton Schroeder</i>		4. DATE OF DEATH Month Day Year <i>March 16 1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-29-52</i>
9. AGE (In years last birthday) <i>7</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Child</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>P.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Delbert L. Schroeder</i>		14. MOTHER'S MAIDEN NAME <i>Lydia L. Chandler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Wash San + Hosp Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>193.0</i> DUE TO <i>Pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <i>Carcinomatosis</i> DUE TO (c) <i>primary medulloblastoma cerebellum</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>31 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>June 1958</i> to <i>March 16, 1960</i> , that (I) (we) last saw the deceased alive on <i>March 15, 1960</i> , and that death occurred <i>4:55 P.M.</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Henry W. Stout</i> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>H. W. STOUT MD</i>		22b. DATE SIGNED	
22d. ADDRESS <i>10011 GEORGIA AVE SILVER SPRING MD.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>3/21/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>ARLINGTON NAT'L. CEMETERY</i>		23d. LOCATION (City, town, or county) (State) <i>ARLINGTON, VIRGINIA</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Pumphrey, Inc.</i>		ADDRESS <i>SILVER SPRING, MD.</i>	
25a. REC'D BY REGISTRAR <i>DATE MAR 18 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>	

80720

CERTIFICATE OF DEATH



Blank certificate form with horizontal lines for text entry.

REGISTERED

INDEXED

Vertical text on the right margin, possibly a date or reference number.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1 8
M
051
2

1
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3628
MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

03567

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Arlington ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington 83x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 3279 S. Stafford St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louis Middle SCHROELL Last SCHROELL				4. DATE OF DEATH Month March Day 29 Year 19 60			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-12-92	
9. AGE (In years lost birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY U.S.Govt.		11. BIRTHPLACE (State or foreign country) Kansas	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Frederick SCHROELL				14. MOTHER'S MAIDEN NAME Ann URQUHART			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 1908-1922				16. SOCIAL SECURITY NO. None		17. INFORMANT Address (W) Mrs. Mary J. Schroell, same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Astrocytoma, grade iii 193.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 3 1/2 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (the deceased) attended the deceased from March 24 19 60 to March 29 19 60 , that (I) (the deceased) last saw the deceased alive on March 29 19 60 , and that death occurred at 2:45 P , from the causes and on the date stated above.							
22a. SIGNATURE M. W. Wood				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3-29-60	
22c. PHYSICIAN'S NAME (Type) M. W. WOOD, LCDR, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3x8 4-1-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Everly Wheatley				ADDRESS Alexandria, Va. 1500 W. Braddock St.		25a. REC'D BY REGISTRAR APR 1 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

1

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 3629 CERTIFICATE OF DEATH 03568

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) olney			c. LENGTH OF STAY IN 1b 13 hrs. 45mins.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Amanda Jane Seal			4. DATE OF DEATH March 6 1960		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/25/1880		9. AGE (In years last birthday) 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Tenn.
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Lafayette Rhea		
14. MOTHER'S MAIDEN NAME Mary Bell			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		
16. SOCIAL SECURITY NO. None			17. INFORMANT Hospital records Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardio-Vascular Disease of Ischemic Type DUE TO Hypertension (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 16 hours 20 years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)			(County)		(State)
21. I certify that (I) (this hospital) attended the deceased from Jan 1935 to March 6 1960 , that (I) (we) last saw the deceased alive on 3/6/1960 , and that death occurred at 1:45 PM from the causes and on the date stated above.					
22a. SIGNATURE M. M. Kendree Boyer			22b. DATE SIGNED March 7, 1960		
22c. PHYSICIAN'S NAME (Type) M. M. Kendree Boyer			22d. ADDRESS Damascus, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 10		23c. NAME OF CEMETERY OR CREMATORY Seal Farm Cemetery	
23d. LOCATION (City, town, or county) Etchison		(State) Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Francis A. Barber			25a. REC'D BY REGISTRAR DATE MAR 14 '60		
ADDRESS Laytonsville, Md.			25b. REGISTRAR'S SIGNATURE Arthur S. Kline		

1950

CERTIFICATE OF DEATH

3682

County of

State of

Dec. 10, 1950

Dec. 10, 1950

Dec. 10, 1950

Dec. 10, 1950

Dec. 10, 1950

Dec. 10, 1950

Dec. 10, 1950

Dec. 10, 1950

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Dec. 10, 1950

Dec. 10, 1950

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3630

CERTIFICATE OF DEATH

03569

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS RFD #1	
3. NAME OF DECEASED (Type or print) First William Middle Edwin Last Seebode		4. DATE OF DEATH Month March Day 23 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1937
9. AGE (In years last birthday) 22 yrs.		10. IF UNDER 1 YEAR Months 1 Days 5 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Auto Parts	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Raymond W. Seebode		14. MOTHER'S MAIDEN NAME Edith A. Johnston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-32-8876	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 3, 1960 to March 23, 1960 , that I last saw the deceased alive on March 23, 1960 , and that death occurred at 3:05A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED March 23, 1960 ACTUAL SIGNATURE CA Chidsey M.D. National Institutes of Health PHYSICIAN'S NAME (Type) Charles A. Chidsey, M.D. Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	22b. DATE THEREOF 3/26/60	22c. NAME OF CEMETERY OR CREMATORY SILVER BROOK	22d. LOCATION (City, town, or county) (State) WILMINGTON DEL
23. FUNERAL DIRECTOR'S SIGNATURE Anne A. Burbage ADDRESS Berlin Md		24a. REC'D BY REGISTRAR MAR 30 '60	24b. REGISTRAR'S SIGNATURE Charles L. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CENTRAL BUREAU OF DEATH

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3631

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE North Carolina b. COUNTY Dare ✓	
b. CITY OR TOWN (If outside corporate limits, write Bethesda (Rural))		c. LENGTH OF STAY IN 1b 77 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS None	

3. NAME OF DECEASED (Type or print) First Benjamin Middle Franklin Last SHANNON		4. DATE OF DEATH Month March Day 5 Year 1960	
5. SEX Male	6. COLOR OR RACE Caucassian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-14-16
9. AGE (In years lost birthday) 43 yrs.		10. IF UNDER 1 YEAR Months 12 Days 12 Hours 12 Min.	11. IF UNDER 24 HRS. Hours 12 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postmaster	10b. KIND OF BUSINESS OR INDUSTRY Govt	11. BIRTHPLACE (State or foreign country) North Carolina	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME John Shannon SR	14. MOTHER'S MAIDEN NAME Sammy Jane Baum
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. 1937-1941	17. INFORMANT Lula R Shannon	Address Manteo, N.C.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, large bowel 153.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 year
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 19 December 59 to 5 March 60 , that I last saw the deceased alive on 5 March 60 , and that death occurred at 9:23 PM , from the causes and on the date stated above.	
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ACTUAL SIGNATURE James M. Young	M.D. U.S. NAVAL HOSPITAL BETHESDA, MD 3-5-60	DATE SIGNED
PHYSICIAN'S NAME (Type) J. M. YOUNG LT MC USN	U.S. NAVAL HOSPITAL BETHESDA, MD.	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-6-60	22c. NAME OF CEMETERY OR CREMATORY Manteo Cemetery	22d. LOCATION (City, town, or county) (State) Manteo Dare North Carolina
23. FUNERAL DIRECTOR'S SIGNATURE Twiford Funeral Home		ADDRESS Manteo, North Carolina	24a. REC'D BY REGISTRAR DATE MAR 9 '60
		24b. REGISTRAR'S SIGNATURE Arthur L. Kraw	

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North Carolina
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John Shannon
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U.S. Naval Hospital, Bethesda, Md.
U.S. Naval Hospital, Bethesda, Md.
J. H. Young, Jr. M.D.

North Carolina
Harris, N.C.
Harris, N.C.
Harris, N.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3488

CERTIFICATE OF DEATH

Reg. Dist. No.

03571

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thoma Park</u>		c. LENGTH OF STAY IN 1b <u>16 Days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia 47X-3</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium Hospital</u>			d. STREET ADDRESS <u>527 Somerset Pl NW</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>ROSE</u> First <u>(NMM)</u> Middle <u>SHENK</u> Last			4. DATE OF DEATH <u>March 15</u> Month <u>15</u> Day <u>1960</u> Year		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-5-80</u>		9. AGE (In years last birthday) <u>79</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Abraham Sherr</u>			14. MOTHER'S MAIDEN NAME <u>unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____	17. INFORMANT <u>Hospital Records</u> Address _____		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> DUE TO <u>442X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>50</u> , to <u>Mar 15</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Mar 14</u> , 19 <u>60</u> , and that death occurred at <u>5:10 A.M.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Simon C. Weiner</u>		M.D. <u>100 Longfellow St NW Wash DC</u>		DATE SIGNED <u>3/15/60</u>	
PHYSICIAN'S NAME (Type) <u>SIMON C. WEINER</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-16-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ELESABETGRAD CEM.</u>	22d. LOCATION (City, town, or county) <u>WASHINGTON</u> (State) <u>D.C.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>B Danzansky & Sons</u>		ADDRESS <u>3501-14 St NW Wash DC</u>	24a. REC'D BY REGISTRAR <u>MAR 17 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "Male"]		RACE [Faint text, possibly "White"]	
DATE OF BIRTH [Faint text, possibly "1900-01-01"]		PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		RESIDENCE [Faint text, possibly "123 Main St, Baltimore, Md."]	
DATE OF DEATH [Faint text, possibly "1950-01-01"]		PLACE OF DEATH [Faint text, possibly "Home"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		SIGNATURE OF PHYSICIAN [Faint text, possibly "J. Smith"]	
SIGNATURE OF REGISTRAR [Faint text, possibly "A. Jones"]		SIGNATURE OF WITNESS [Faint text, possibly "B. Brown"]		SIGNATURE OF DECEASED [Faint text, possibly "John Doe"]	
DATE OF REGISTRATION [Faint text, possibly "1950-01-01"]		PLACE OF REGISTRATION [Faint text, possibly "Baltimore, Md."]		SIGNATURE OF REGISTRAR [Faint text, possibly "A. Jones"]	

TO THE DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please explain the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO THE FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3632 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

File # G261 4-20-60 et

Reg. Dist. No.

03572

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rockville R-2</u>	
c. LENGTH OF STAY IN 1b <u>5 min.</u>		d. STREET ADDRESS <u>Scotland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Vincent</u> Middle <u>Shepard</u> Last <u>Shepard</u>		4. DATE OF DEATH Month <u>Mar</u> Day <u>6</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ?
9. AGE (In years last birthday) <u>34</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10b. KIND OF BUSINESS OR INDUSTRY ?	
11. BIRTHPLACE (State or foreign country) ?		12. CITIZEN OF WHAT COUNTRY? ?	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>V</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>stroke</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>3-10-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>University of Medicine School</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u>		24a. REC'D BY REGISTRAR <u>APR 1 '60</u>	
ADDRESS <u>108 N. Wash. St. Rockville</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MEDICAL CERTIFICATION

2

BP

3832 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 TOWN OF BATHING - BATHING 18

NAME OF DECEASED _____		SEX _____	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		OCCUPATION _____	
MARITAL STATUS _____		CAUSE OF DEATH _____	
TIME OF DEATH _____		PLACE OF DEATH _____	
SIGNATURE OF EXAMINER _____		SIGNATURE OF WITNESS _____	
DATE _____		TIME _____	
PLACE _____		COUNTY _____	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 VS A15 (4)
 15M 10/57

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Item 9 Film 6258 3-10-60 et 3633 CERTIFICATE OF DEATH

03573

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery Co.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Virginia</i> b. COUNTY <i>Alexandria</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Alexandria Virginia 83X-3</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Desmar Law</i>				d. STREET ADDRESS <i>1225 Stafford Road</i>			
3. NAME OF DECEASED (Type or print) First <i>Dr. Joseph</i> Middle <i>Shohan</i> Last <i>Shohan</i>				4. DATE OF DEATH Month <i>3</i> Day <i>4</i> Year <i>1960</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 22 1874</i>	
9. AGE (In years last birthday) <i>85 8/16</i> yrs.		IF UNDER 1 YEAR Months <i>4</i> Days <i>19</i> Hours <i>60</i> Min.		IF UNDER 24 HRS. Months <i>4</i> Days <i>19</i> Hours <i>60</i> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dr.</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Physician</i>		11. BIRTHPLACE (State or foreign country) <i>Poland</i>	
13. FATHER'S NAME <i>William Shohan</i>				14. MOTHER'S MAIDEN NAME <i>Hannah P</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT Address <i>Charles F Shohan-son-same as 2d</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiovascular collapse</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>generalized arteriosclerosis</i> DUE TO (c) <i></i>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Carcinoma of sigmoid with general metastasis</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <i>2/13</i> , 19 <i>60</i> , to <i>3/4</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>3/28</i> , 19 <i>60</i> , and that death occurred at <i>5:34</i> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Wilfred R. Ehrmantraut</i> M.D.				ADDRESS (Street, city or town, state) <i>4890 Patton Lane, Bethesda</i>			
PHYSICIAN'S NAME (Type) <i>Wilfred R. Ehrmantraut M.D.</i>				DATE SIGNED <i>3/4/60</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/8/60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Comfort Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Alexandria, Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Rumphrey</i>				ADDRESS <i>Bethesda, Maryland</i>		24a. REC'D BY REGISTRAR <i>7 '60</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>			

MEDICAL CERTIFICATION

090

I

1

20

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES			

CERTIFICATE OF DEATH

Reg. Dist. No.

03574

3489

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u>				c. LENGTH OF STAY IN 1b <u>10 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth Clarinda Shorey</u> First Middle Last				4. DATE OF DEATH Month <u>3</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-11-84</u>	9. AGE (In years last birthday) <u>75 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John Burkart</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Young</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>?</u> INFORMANT <u>Mrs. John C. Bahr, Philadelphia, Pa</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asystole - Complete Heart Block</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Arteriosclerosis + Hypertension Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arteriosclerosis & Infarction, Nephrosclerosis</u> Joint							INTERVAL BETWEEN ONSET AND DEATH <u>6 mo?</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>2/17</u> , 19 <u>60</u> , to <u>3/9</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/9</u> , 19 <u>60</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ruth B. Benedict M.D.</u> M.D.				ADDRESS (Street, city or town, state) <u>1808 Conn Ave N.W. Wash. D.C.</u> DATE SIGNED <u>3/12/60</u>			
PHYSICIAN'S NAME (Type) <u>RUTH B. BENEDICT.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 14, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> ADDRESS <u>254 Carroll St N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Rouse</u>	

CERTIFICATE OF DEATH

36-9

278

[Faint, mostly illegible text and lines on a death certificate form. The form includes sections for personal information, cause of death, and medical history.]

STATE OF NEW YORK

DEPARTMENT OF HEALTH

3634 CERTIFICATE OF DEATH

Reg. Dist. No.

03575

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 52 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle Eugene Last Shunk				4. DATE OF DEATH Month March Day 18 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 14, 1944	
9. AGE (In years last birthday) 15 yrs.		IF UNDER 1 YEAR Months 12 Days X Hours 2 Min.		IF UNDER 24 HRS. Hours 12 Min. X			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Carl H. Shunk				14. MOTHER'S MAIDEN NAME Marcella E. Pearce			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Massive metastasis to the left lung DUE TO (c) Metastatic osteogenic sarcoma							
INTERVAL BETWEEN ONSET AND DEATH 2 months 6 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from January 26, 1960 to March 18, 1960 , that I last saw the deceased alive on March 18, 1960 , and that death occurred at 6:55 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard C. Mechanic				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3/18/60			
PHYSICIAN'S NAME (Type) Richard C. Mechanic, M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 21, 1960		22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		22d. LOCATION (City, town, or county) (State) Bel Air Harford Md.,	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McConer Jr. ADDRESS Abingdon, Md.,				24a. REC'D BY REGISTRAR MAR 23 '60		24b. REGISTRAR'S SIGNATURE Carlton S. Kraus	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

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• *Staphylococcus aureus*

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE STATE
OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

1. Name of Deceased: John J. Smith

2. Sex: Male

3. Age: 45

4. Date of Death: April 1, 1914

5. Place of Death: Home

6. Cause of Death: Heart Disease

7. Signature of Medical Examiner: John J. Smith

8. Signature of Coroner: John J. Smith

9. Signature of Registrar: John J. Smith

10. Signature of Burial Officer: John J. Smith

11. Signature of Undertaker: John J. Smith

12. Signature of Minister: John J. Smith

13. Signature of Priest: John J. Smith

14. Signature of Rabbi: John J. Smith

15. Signature of Imam: John J. Smith

16. Signature of Other: John J. Smith

17. Signature of Other: John J. Smith

18. Signature of Other: John J. Smith

19. Signature of Other: John J. Smith

20. Signature of Other: John J. Smith

1

THE STATE
OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
3635
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03576

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fulton</u> <u>13X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Homer</u> Middle <u>Milton</u> Last <u>Simons</u>		4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>19 60</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/13/11</u>	9. AGE (In years last birthday) <u>18</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Allen John Simons</u>				14. MOTHER'S MAIDEN NAME <u>Delilah Boss</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-05-0708</u>		17. INFORMANT <u>Hospital Records</u>		Address <u>Olney, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary carcinoma of the liver with metastases</u> <u>155.0</u> DUE TO <u>to hilar, abdominal and aortic lymph nodes</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 15</u> 19 <u>59</u> , to <u>Mar. 1</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Mar. 1</u> 19 <u>60</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>C. S. Whitaker,</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/1/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. S. Whitaker, M. D.</u>				22d. ADDRESS <u>Clarksville, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/5/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Louis Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Clarksville Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>McWitt Sandelton, Laurel, Md</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 7 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Conner S. Kraus</u>	

1957

CERTIFICATE OF DEATH

303

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200800101

11/11/2008

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3636

CERTIFICATE OF DEATH

Reg. Dist. No.

03577

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>57 Bethesda</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>15508 McKimley St</i>	
3. NAME OF DECEASED (Type or print) First <i>Alice</i> Middle <i>Sparks</i> Last <i>Sparks</i>		4. DATE OF DEATH <i>March 21 1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/31/97</i>
9. AGE (In years last birthday) <i>62</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Kansas</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Bobek</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>James J. Sparks</i>		Address <i>same as above</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>433.1 Congestive Heart failure</i> (b) <i>Dilatation Right Atrium & ventricle</i> (c) <i>Atrial fibrillation</i> INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>unknown</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Multiple myeloma involving vertebral column, ribs & left frontal lobe of brain</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 20, 1960</i> , to <i>March 21, 1960</i> , that I last saw the deceased alive on <i>March 21, 1960</i> , and that death occurred at <i>5:45 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert W. Humphrey, M.D.</i>		ADDRESS (Street, city or town, state) <i>1746 R St. N.W. Washington D.C.</i>	
PHYSICIAN'S NAME (Type) <i>Charles W. Humphrey, M.D.</i>		DATE SIGNED <i>3/21/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>3/22/60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Crematory</i>		22d. LOCATION (City, town, or county) (State) <i>Suitland, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert W. Humphrey</i>		ADDRESS <i>Bethesda, Maryland</i>	
24a. REC'D BY REGISTRAR <i>MAR 28 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	

3638 CERTIFICATE OF DEATH

1977

3515

CERTIFICATE OF DEATH

03578

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville 26			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1918 Gainsboro Rd.				d. STREET ADDRESS 1918 Gainsboro Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HELEN		First ELIZABETH		Last SPURRIER		4. DATE OF DEATH Month March Day 14 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 30, 1928		9. AGE (In years last birthday) 31 yrs.	IF UNDER 1 YEAR Months 9 Days 14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Aubrey Edwards				14. MOTHER'S MAIDEN NAME Helen E. Birch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-34-8015		INFORMANT Address Earl L. Spurrier-Item# 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 201X IMMEDIATE CAUSE (a) Hodgkin's Disease DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 Feb. 1960 to 14 March 1960 that I last saw the deceased alive on 13 March 1960, and that death occurred at 2:13 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED W G Hall M.D. 615 W. MONTGOMERY AVE. ROCKVILLE, MD. 3-14-60 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) W.G. Hall 615 W. Montg. Ave., Rockville, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/16/60		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Silver Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler-1331 E. Montg. Ave.				24a. REC'D BY REGISTRAR DATE MAR 16 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hump	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS
COUNTY OF DALLAS

1900

WILLIAM J. BROWN

10

11

12

13

17
FOR STATE
HEALTH DEPT. **M**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

3637 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

68579

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balt.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>7</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Lincoln Mill Rd + Ennals Ave</u>		d. STREET ADDRESS <u>2700 Gwynnmore Ave</u>	
3. NAME OF DECEASED (Type or print) <u>James David Staggs</u>		4. DATE OF DEATH <u>Mar 16 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>37</u> <u>12-24-22</u> yrs.
10a. USUAL OCCUPATION (Give kind of work performed on a regular basis, if tenured) <u>electrician</u>		11. BIRTHPLACE (State or foreign country) <u>Ky.</u>	
13. FATHER'S NAME <u>JAMES O. Staggs</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>216-34-8998</u>	
17. INFORMANT <u>E.H. Johnson</u>		Address <u>2700 Gwynnmore Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrocution</u> 914.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>914.5</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was in truck repairing sign when boom contacted high tension wire</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>12:43</u> p.m. <u>3-16 1960</u>	2Dd. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>street</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		20f. (City or town) <u>Wheaton</u> (County) <u>Montg</u> (State) <u>md</u>	
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DATE SIGNED <u>3-16-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-19-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Good Shepherd</u>		22d. LOCATION (City, town, or country) (State) <u>Rockdale Md.</u>	
23. FUNERAL DIRECTOR <u>Geo L. Schwab FUNERAL HOME</u>		24a. REC'D BY REGISTRAR <u>MAR 21 '60</u>	
ADDRESS <u>Francis H. Wyller 2101 Franklin Ave.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

3083 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MAY 11 1968

CERTIFICATE OF DEATH

Reg. Dist. No.

03580

3638

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 152 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Cedric Middle Richard Last (KNUTH) Stahl				4. DATE OF DEATH Month March Day 15 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 4, 1927	
9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR Months 32 Days 15 Hours 19 Min. 2		IF UNDER 24 HRS. Months 32 Days 15 Hours 19 Min. 2			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Engineer				10b. KIND OF BUSINESS OR INDUSTRY Aviation		11. BIRTHPLACE (State or foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Albert Knuth				14. MOTHER'S MAIDEN NAME Lucille Schulz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II				16. SOCIAL SECURITY NO. 360-18-1898			
INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial hemorrhage DUE TO 204.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gastro-intestinal hemorrhage DUE TO (c) Acute myelogenous leukemia							
INTERVAL BETWEEN ONSET AND DEATH unknown unknown 5 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 204.3							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from October 15 , 19 59 , to March 15 , 19 60 , that I last saw the deceased alive on March 15 , 19 60 , and that death occurred at 10:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3/15/60 ACTUAL SIGNATURE Harold J. Fallon M.D. The Clinical Center PHYSICIAN'S NAME (Type) Harold J. Fallon, M.D. National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, or REMAIN (Specify) SHMP R.R.				22b. DATE THEREOF 3-16-1960			
22c. NAME OF CEMETERY OR CREMATORY Wash D.C.				22d. LOCATION (City, town, or county) (State) Chicago, Ill.			
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers ADDRESS 500 11th St SE				24a. REC'D BY REGISTRAR DATE MAR 17 '60			
24b. REGISTRAR'S SIGNATURE Arthur S. Kneel							

1

hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

STATE OF MARYLAND
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
FEBRUARY 1950

10

County Prince Georges Maryland

Address 122 days Northampton

The Clinical Center, Bethesda, Md., 5020 Eglinton Drive

Birth Date March 1927

Sex Male

Occupation Electrical Engineer Aviation

Place of Birth Illinois

Place of Birth Illinois

Place of Birth Illinois

Place of Birth Illinois

Place of Birth Illinois

March 15 1927

The Clinical Center
National Institutes of Health
Bethesda, Maryland

March 15 1927

March 15 1927

3490 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D. C.</i> b. COUNTY <i>-</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sakoma Park</i>				c. LENGTH OF STAY IN 1b <i>9 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Heath San & Hospital</i>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> <i>47X-3</i>			
f. STREET ADDRESS <i>1 Scott Circle NW apt 617</i>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Nettie May Stearns</i>				4. DATE OF DEATH <i>March 12 1960</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan 26 1893</i>	
9. AGE (In years last birthday) <i>87</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Maine</i>			
11. BIRTHPLACE (State or foreign country) <i>Maine</i>				12. CITIZEN OF WHAT COUNTRY? <i>AMERICA</i>			
13. FATHER'S NAME <i>Nathaniel Eldridge</i>				14. MOTHER'S MAIDEN NAME <i>Victoria Brackett</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>no</i>			
17. INFORMANT <i>g's chert & daughter</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> <i>434.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Congestive Heart Failure</i> DUE TO (c) <i>3-4 yrs.</i>							INTERVAL BETWEEN ONSET AND DEATH <i>2-3 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3-3</i> , 19 <i>60</i> , to <i>3-12</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>3-12</i> , 19 <i>60</i> , and that death occurred at <i>5:30 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Robert B. Irey</i>				ADDRESS (Street, city or town, state) <i>7105 Riggs Rd. Hyattsville, Md.</i>			
PHYSICIAN'S NAME (Type) <i>ROBERT B. IREY</i>				DATE SIGNED <i>3-12-60</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		22b. DATE THEREOF <i>3/14/60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Cambridge, Mass.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. S. King Co 2901-14 St NW</i>				24a. REC'D BY REGISTRAR <i>MAR 15 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. King</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

No. 10

John Doe, of the County of ... State of ...
born ... died ...

at the residence of ...
on the ... day of ...

at the age of ... years ...
months ... days ...

caused by ...
the result of ...

the attending physician ...
and the medical examiner ...

both of whom are duly licensed ...
and the coroner ...

both of whom are duly licensed ...
and the coroner ...

both of whom are duly licensed ...
and the coroner ...

both of whom are duly licensed ...
and the coroner ...

both of whom are duly licensed ...
and the coroner ...

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G258 3/11/60 iwk

3639

CERTIFICATE OF DEATH

Reg. Dist. No.

03582

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b D.O.A.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Walter Middle S. Last Steele				4. DATE OF DEATH Month 3 Day 2 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/2/1890	
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 70 Days 6 Hours 2 Min.		11. IF UNDER 24 HRS. Hours 2 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Magazine Publisher				10b. KIND OF BUSINESS OR INDUSTRY Natl. Republic Mag.			
11. BIRTHPLACE (State or foreign country) Kentucky				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Samuel Steele				14. MOTHER'S MAIDEN NAME Alice Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 578-09-6115			
17. INFORMANT Wife -				Address same as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Cardiac Temporal Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Rupture of Myocardium (c) Myocardial Infarction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sudden Sudden Days							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/1/58 to 3/2/60 , that I last saw the deceased alive on 3/2/60 , and that death occurred at 9:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rockville, Md. DATE SIGNED 3/2/60							
ACTUAL SIGNATURE Stephen Jones, M.D.				M.D. Rockville, Maryland			
PHYSICIAN'S NAME (Type)				ADDRESS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/5/60		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		22d. LOCATION (City, town, or county) (State) Silver Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				24a. REC'D BY REGISTRAR MAR 7 '60			
ADDRESS Bethesda, Maryland				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3613

3613

RECEIVED AT THE OFFICE OF THE SECRETARY OF THE ARMY
WASHINGTON, D. C. 20315
JAN 10 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3491
CERTIFICATE OF DEATH

03583

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. LENGTH OF STAY IN 1b <u>2 1/2 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cedar Haven Rest Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>Elizabeth</u> Last <u>STEWART</u>				4. DATE OF DEATH Month <u>3</u> Day <u>4</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/18/81</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>18</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Kent Island, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>							
13. FATHER'S NAME <u>Pere S. Winchester</u>				14. MOTHER'S MAIDEN NAME <u>Katherine E. White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Rae Stewart 8500 16th Street Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis (vascular)</u> 331X DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Diabetes Mellitus</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>gangrene both lower extremities</u> INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>10 years</u> <u>3 years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>January 5, 1960</u> to <u>March 4, 1960</u> that (I) (we) last saw the deceased alive on <u>March 4, 1960</u> , and that death occurred at <u>6 P</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Max G. Sherer</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>3/4/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>MAX G. SHERER, MD</u>				22d. ADDRESS <u>2025 EAST W. 1st H'way Sil. Sp. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>3/7/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	
23d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>				(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR <u>MAR 11 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kiana</u>	

CERTIFICATE OF DEATH

IN THE DISTRICT OF COLUMBIA
OFFICE OF THE REGISTRAR OF DEATHS

1913

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Date of death: _____
6. Place of death: _____
7. Cause of death: _____
8. Signature of Registrar: _____
9. Signature of Physician: _____
10. Signature of Coroner: _____
11. Signature of Burial Officer: _____
12. Signature of Undertaker: _____
13. Signature of Witness: _____
14. Signature of Minister: _____
15. Signature of Priest: _____
16. Signature of Rabbi: _____
17. Signature of Imam: _____
18. Signature of Other: _____
19. Signature of Other: _____
20. Signature of Other: _____
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95. Signature of Other: _____
96. Signature of Other: _____
97. Signature of Other: _____
98. Signature of Other: _____
99. Signature of Other: _____
100. Signature of Other: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3503

CERTIFICATE OF DEATH

03584

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3813 Williams Lane		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 58 Chevy Chase d. STREET ADDRESS 3813 Williams Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lulah Middle Davidson Last Stout		4. DATE OF DEATH Month March Day 7 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/12/81
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dr. Marshall M. Davidson		14. MOTHER'S MAIDEN NAME Roaine Wells	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. nos	
17. INFORMANT Jane E. Call		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal + Cardiac failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-vascular-renal disease DUE TO (c) 1 disease			INTERVAL BETWEEN ONSET AND DEATH 2 mos. 20 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Mar. 19, 46 to Mar. 7, 1960 , that I last saw the deceased alive on Mar. 4, 1960 , and that death occurred at 8:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip H. Varner		ADDRESS (Street, city or town, state) 7702 Camp Ave., Chevy Chase, Md.	
PHYSICIAN'S NAME (Type) Philip H. Varner		DATE SIGNED 3-7-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) removal	22b. DATE THEREOF 3/8/60	22c. NAME OF CEMETERY OR CREMATORY Rock Spring Cemetery	22d. LOCATION (City, town, or county) (State) Fauber, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR 2901 14th St. N.W. Washington 9, D.C.	24b. REGISTRAR'S SIGNATURE DATE MAR 10 '60

CERTIFICATE OF DEATH

Reg. Dist. No.

03585

3640

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Indiana b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 141 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH Month March Day 29 Year 1960		5. DATE OF DEATH Month March Day 29 Year 1960	
3. NAME OF DECEASED (Type or print) First David Middle O'Neal Last Strange	6. COLOR OR RACE White		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 13, 1950		
9. AGE (In years lost birthday) yrs. 10	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William W. Strange		14. MOTHER'S MAIDEN NAME Bessie J. Dilbeck	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic Bronchopneumonia with Abscesses DUE TO (b) Hypoplastic Anemia (Fanconi) and Thrombocytopenia and Leukopenia DUE TO (c) Hypersteroidism (drug-induced)		INTERVAL BETWEEN ONSET AND DEATH 3 - 4 days 3 years (congenital?) 13 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 9, 1959 , to March 29, 1960 , that I last saw the deceased alive on March 29, 1960 , and that death occurred at 8:45 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Archie A. Mackinney Jr.		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED March 30, 1960	
PHYSICIAN'S NAME (Type) Archie A. Mackinney, Jr., M.D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) SHIP RR.	22b. DATE THEREOF 3-30-1960	22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	22d. LOCATION (City, town, or county) (State) Evansville Ind
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers		24a. REC'D BY REGISTRAR Wash. D.C. DATE APR 4 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3641

CERTIFICATE OF DEATH

Reg. Dist. No. 215

03586

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN lb 60 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Quantico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 83X-3 d. STREET ADDRESS 2766 "V" e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Joseph Louis STRATMANN				4. DATE OF DEATH Month Day Year March 20 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-2-19		9. AGE (In years last birthday) yrs. 40	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Louis (n) Stratmann				14. MOTHER'S MAIDEN NAME Minnie ELDERMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW II		INFORMANT (Wife) Dorothy E. Stratmann		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 294X DUE TO Polycythemia Vera c Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cerebral and pulmonary infection (c) 8 mos.						INTERVAL BETWEEN ONSET AND DEATH 8 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sub Total gastrectomy							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 20 January , 19 60 , to 20 March , 19 60 , that I lost sow the deceased olive on 20 March , 19 60 , and that death occurred at 10:58PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 3-21-60							
ACTUAL SIGNATURE W.D. HOOFER		M.D. U.S. Naval Hospital, Bethesda, Md. 3-21-60					
PHYSICIAN'S NAME (Type) W.D. HOOFER LT MC USN		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 3/22/60		22b. DATE THEREOF 3/22/60		22c. NAME OF CEMETERY OR CREMATORY Memorial Park		22d. LOCATION (City, town, or county) (State) Vincennes Indiana	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers 1400 Chapin Street N.W. Washington				24a. REC'D BY REGISTRAR D. CMAR 2 4 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES DEPARTMENT OF COMMERCE
BUREAU OF COMMERCE

Washington, D.C.

June 1, 1914

U.S. Naval Hospital, Baltimore, Md.

James J. Jones

U.S. Marine Corps

U.S. Government

U.S. Navy

U.S. Army

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

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U.S. Navy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3642
CERTIFICATE OF DEATH

03587

1. PLACE OF DEATH a. COUNTY Montgomery County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda,		MARYLAND c. LENGTH OF STAY IN 1b 23 years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4815 Edgefield Rd.		d. STREET ADDRESS 4815 Edgefield Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Herbert M. Stroud		4. DATE OF DEATH Month Day Year March 15 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9-14-1874	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 6 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Ironia, New Jersey	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Samuel V. Stroud		14. MOTHER'S MAIDEN NAME Josephine Latimore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT W.A. Stroud - son - same as 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> ot work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 3/12 1960	
20f. (City or town) 3/15/1960		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 3/12 1960 to 3/15/1960 , that (I) (we) last saw the deceased alive on 3/14/1960 , and that death occurred at 2 AM , from the causes and on the date stated above.					
22a. SIGNATURE W. T. Joyce		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/15/60	
22c. PHYSICIAN'S NAME (Type) W. T. Joyce, M.D.		22d. ADDRESS 8106 Maple Ridge Rd. Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 3/16/60		23b. DATE THEREOF 3/16/60		23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	
23d. LOCATION (City, town, or county) Warren, Pennsylvania		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR MAR 17 '60	
25b. REGISTRAR'S SIGNATURE Cynthia S. Hanna					

CERTIFICATE OF MARRIAGE

Married at _____
on the _____ day of _____
19____ at _____
between _____
and _____
both of legal age and sound mind
and of the County of _____
State of _____
and the same being freely and lawfully
contracted by them in accordance with the
provisions of the laws of the State of _____
and the same being duly solemnized by me,
the undersigned, a Minister of the Gospel,
and the same being duly recorded in the
proper books of the County of _____
State of _____
I hereby certify that the foregoing is a true and
correct copy of the original of the same as
the same appears from the records of the
County of _____
State of _____
this _____ day of _____
19____
at _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3643

CERTIFICATE OF DEATH

Reg. Dist. No. 03588

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 5 1/2 days (11 1/2 Hrs) X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Catherine Middle Sullivan Last Sullivan		4. DATE OF DEATH Month March Day 13 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/29/72
9. AGE (In years last birthday) 87 yrs.		10. UNDER 1 YEAR Months 87 Days 87 Hours 87 Min. 87	11. UNDER 24 HRS. Months 87 Days 87 Hours 87 Min. 87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Joseph P White		14. MOTHER'S MAIDEN NAME Katherine Bohama	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No If yes, give war or dates of service		16. SOCIAL SECURITY NO. None	
17. INFORMANT Granddaughter Mrs. Robt. Barclay		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 540.1 DUE TO Generalized Peritonitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Perforated Gastric Ulcer DUE TO Chronic Gastric Ulcer (c) Chronic Gastric Ulcer PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Status post gastrectomy INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 12:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10609 Concord St. Kensington, Md. DATE SIGNED 3/13/60			
ACTUAL SIGNATURE Robert J. Thibadeau		PHYSICIAN'S NAME (Type) Robert J. Thibadeau 10609 Concord St. Kensington, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/16/60	
22c. NAME OF CEMETERY OR CREMATORY St. Jeromes Cemetery		22d. LOCATION (City, town, or county) (State) Schuylkill Co. Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR MAR 16 '60	
ADDRESS Bethesda, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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VS A15 (4)
15M 9/58

TO VITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3644

CERTIFICATE OF DEATH

Reg. Dist. No. 03589

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 7 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. Gen. Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		f. STREET ADDRESS 26745 Howard Chapel Dr.	
3. NAME OF DECEASED (Type or print) First Gwen Middle D. Last Tabler				4. DATE OF DEATH Month March Day 19 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 23, 1918	
9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months 2 Days 15 Hours 15 Min.		11. IF UNDER 24 HRS. Hours 15 Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier -				10b. KIND OF BUSINESS OR INDUSTRY Montg. Co. Gov't nr Damascus, Md.			
11. BIRTHPLACE (State or foreign country) USA				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Frank E. Duvall				14. MOTHER'S MAIDEN NAME Irene L. King			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 218-20-0354			
17. INFORMANT Albert S. Tabler, Jr.				Address Damascus, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Purpura Hemorrhagica DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Abdominal Carcinomatosis (Primary adenocarcinoma of the stomach) DUE TO (c) ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Furunculosis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.							
20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan. 26, 1960 to March 19, 1960 , that I last saw the deceased alive on March 18, 1960 , and that death occurred at 4:10am from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 9830 Main Street Damascus, Md.							
DATE SIGNED 3/19/60							
ACTUAL SIGNATURE M. McKendree Boyer, M. D.							
PHYSICIAN'S NAME (Type) M. McKendree Boyer, M. D. Damascus, Maryland.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF 3/21/60							
22c. NAME OF CEMETERY OR CREMATORY Damascus Meth.							
22d. LOCATION (City, town, or county) (State) Damascus, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Chas. L. Molsworth							
ADDRESS Damascus, Md.							
24a. REC'D BY REGISTRAR MAR 22 '60							
24b. REGISTRAR'S SIGNATURE Arthur S. King							

CERTIFICATE OF DEATH

1914

1

NAME

AGE

SEX

RESIDENCE

DATE

TIME

PLACE

CAUSE

SIGNATURE

DATE

TIME

PLACE

CAUSE

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DATE

TIME

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CAUSE

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3492

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Damascus</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San. Hosp.</i>		1. d. STREET ADDRESS <i>26812 Howard Chapel Dr.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Thomas Byard Tabler</i>		4. DATE OF DEATH Month Day Year <i>March 8 1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Wh.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 19, 1885</i>
9. AGE (In years lost birthday) <i>74</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Levi A. Tabler</i>		14. MOTHER'S MAIDEN NAME <i>Alveta Lewis</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-16-2111A</i>	
17. INFORMANT <i>Pt's. Hospital Record</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Exsanguination, Shock</i> 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Rupture Abdominal Aortic Aneurysm</i> DUE TO (c) <i>Atherosclerosis Aorta & Generalized</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i> <i>3 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3-8</i> , 19 <i>60</i> , to <i>3-8</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>3-8</i> , 19 <i>60</i> , and that death occurred at <i>8:05 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Marvin L. Kolkin</i> M.D.		ADDRESS (Street, city or town, state) <i>8485 Fenton Street, S.S. Md</i>	
PHYSICIAN'S NAME (Type) <i>Marvin L. Kolkin</i>		DATE SIGNED <i>3/9/60</i>	
22a. BURIAL, CREMATION, REBURY (Specify) <i>Reburied</i>		22b. DATE THEREOF <i>3-11-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Kempton</i>		22d. LOCATION (City, town, or county) (State) <i>Kempton, Mont. Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Francis H. Barber - Laytonville Md.</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>MAR 15 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
CERTIFICATE OF DEATH

1912

Name of Deceased		Age		Sex		Race		Color	
John J. Smith		45		Male		Caucasian		White	
Place of Birth		Date of Birth		Date of Death		Cause of Death		Manner of Death	
New York City		Jan 15, 1867		Jan 10, 1912		Heart Disease		Natural	
Occupation		Education		Marital Status		Religion		Burial Place	
Clerk		High School		Married		Roman Catholic		St. Mary's Church	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Minister		Signature of Undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Death		City		County		State	
Jan 12, 1912		New York City		New York		New York		New York	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A1SME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
3645 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03591											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>M</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>20 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>55-23 Southview St</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>57 Bethesda</u> d. STREET ADDRESS <u>55-23 Southview St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Alma Estelle Talbert</u>		4. DATE OF DEATH <u>mar 18 1960</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/20/1887</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>28</u> IF UNDER 24 HRS. Hours <u>---</u> Min. <u>---</u>	
13. FATHER'S NAME <u>Francis Tucker</u>				14. MOTHER'S MAIDEN NAME <u>Ella Pasay</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>Yes-Unknown</u>				17. INFORMANT <u>Ellen Cursten (daughter)</u>				Address <u>9827 Markham St Silver Spring, md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>---</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broseant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>3-18-60</u>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSEANT</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/21/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Washington, D. C.</u>			
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>						ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>MAR 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

3646

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03592

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 57 Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7701 Chelton Drive Road		d. STREET ADDRESS 7701 Chelton Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Margaret Stafford TAYLOR		4. DATE OF DEATH Month Day Year Mar. 27, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3, 1907
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 52	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Stephen Stafford		14. MOTHER'S MAIDEN NAME Mattie G. Perrie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Husband Charles Taylor		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden Years			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BROSCHART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/30/60	
22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE MAR 30 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1944

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
OCCUPATION [REDACTED]		CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]	
MEDICAL HISTORY [REDACTED]		PHYSICAL EXAMINATION [REDACTED]		LABORATORY EXAMINATIONS [REDACTED]	
POST-MORTEM EXAMINATION [REDACTED]		TOXICOLOGICAL EXAMINATIONS [REDACTED]		OTHER EXAMINATIONS [REDACTED]	
SIGNATURE OF MEDICAL EXAMINER [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF CORONER [REDACTED]	
DATE OF SIGNATURE [REDACTED]		TIME OF SIGNATURE [REDACTED]		PLACE OF SIGNATURE [REDACTED]	

CERTIFICATE OF DEATH

Reg. Dist. No. 215

3647

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE South Carolina b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Marie Middle Elizabeth Last TAYLOR				4. DATE OF DEATH Month March Day 9 Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-24-59	9. AGE (In years last birthday) 2 yrs.	IF UNDER 1 YEAR Months 2 Days 14	IF UNDER 24 HRS. Hours 14 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Charles W. Taylor				14. MOTHER'S MAIDEN NAME Laura REEVES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT (Father) Charles W. Taylor		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) anoxia- 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Interstitial pneumonia involving both lungs - total hepaticization DUE TO (c) pneumocystis carinii or Hamman-Rich PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b). Severe pulmonary hypertension with right ventricular hypertrophy and strain							INTERVAL BETWEEN ONSET AND DEATH 5 min 10 days 2 wks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 March 1960 to 9 March 1960 , that I last saw the deceased alive on 9 March 1960 , and that death occurred at 4:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE G.B. Avery				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.			
DATE SIGNED 3-10-60							
PHYSICIAN'S NAME (Type) G.B. AVERY LT MC USN				U.S. Naval Hospital, Bethesda Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF SHIPMENT 3-10-60		22c. NAME OF CEMETERY OR CREMATORY Memorial Park		22d. LOCATION (City, town, or county) (State) Lancaster South Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				ADDRESS 7557 Wisconsin Ave. Bethesda Md.		24a. REC'D BY REGISTRAR MAR 14 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Fries			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9VVVVV VVXVV

3648

CERTIFICATE OF DEATH

03594

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE South Carolina b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 22 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seneca 77X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Route # 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ralph Middle Davis Last Taylor				4. DATE OF DEATH Month March Day 26 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 15, 1923	
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Parts Salesman				10b. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Davis Taylor				14. MOTHER'S MAIDEN NAME Elizabeth Carpenter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW II				16. SOCIAL SECURITY NO. Unascertainable			
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 193.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral glioma DUE TO (c) 4 years							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 4, 1960 , to March 26, 1960 , that I last saw the deceased alive on March 26, 1960 , and that death occurred at 12:35 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph J. Adamkiewicz, M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3/26/60			
PHYSICIAN'S NAME (Type) Joseph J. Adamkiewicz, M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3-27-1960		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) SENECA S.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers ADDRESS 400 Chapin St, N.W.				24a. REC'D BY REGISTRAR DATE MAR 29 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

VS A15 (4)
15M 9/58

STATE OF TEXAS
COUNTY OF DALLAS

1900

WITNESSES

NOTARY

ATTEST: My commission expires this 1st day of January, 1901.

NOTARY PUBLIC, STATE OF TEXAS

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 443. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

<div> <div>Item 18 File 262 5-9-60</div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>3452 MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>03596</div> </div>												
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> c. LENGTH OF STAY IN 1b <i>8 yrs</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>11026 Burnley Ter</i>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Montg</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>56 Silver Spring</i> d. STREET ADDRESS <i>11026 Burnley Ter</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Octavia Gilbert Thornton</i>			4. DATE OF DEATH Month <i>Mar</i> Day <i>14</i> Year <i>1960</i>		5. SEX <i>Female</i>			6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <i>11-3-1918</i>			9. AGE (In years last birthday) <i>41 yrs.</i>		IF UNDER 1 YEAR Months <i>14</i> Days <i>18</i>		IF UNDER 24 HRS. Hours <i>19</i> Min. <i>60</i>		10a. USUAL OCCUPATION (Give kind of work done in neighborhood) <i>Housewife</i>			
10b. KIND OF BUSINESS OR INDUSTRY <i>Handley Ford Dealer</i>			11. BIRTHPLACE (State or foreign country) <i>S.C.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.C.</i>						
13. FATHER'S NAME <i>Mathew H. Gilbert</i>					14. MOTHER'S MAIDEN NAME <i>Josie Olsen</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>			16. SOCIAL SECURITY NO. <i>247-01-0068</i>			17. INFORMANT <i>Deborah Thornton - Steen</i> Address <i>2</i>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Undetermined</i> <i>795.5</i> DUE TO (b) <i>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.</i> DUE TO (c) <i>795.5</i>										INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Brosch</i>			EXAMINER'S NAME (Type) <i>FRANK J. BROSCHE</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <i>3-15-60</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>TRANS. & BURIAL</i>			22b. DATE THEREOF <i>3/17/60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i>			22d. LOCATION (City, town, or country) (State) <i>Greenville, South Carolina</i>				
23. FUNERAL DIRECTOR <i>WARNER E. PUMPHREY, INC.</i>			ADDRESS <i>SILVER SPRING, MD.</i>			24a. REC'D BY REGISTRAR <i>Raymond L. Gaska</i>			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			



DECEASED: [Name]
AGE: [Age]
SEX: [Sex]
RACE: [Race]
DATE OF DEATH: [Date]
PLACE OF DEATH: [Place]
CAUSE OF DEATH: [Cause]
MANNER OF DEATH: [Manner]
SIGNATURE OF EXAMINER: [Signature]
OFFICE OF EXAMINER: [Office]
CITY: [City]
STATE: [State]



RECEIVED BY THE STATE DEPARTMENT OF HEALTH

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 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

03597

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8604 Grant St.		e. STREET ADDRESS 8604 Grant Street	
3. NAME OF DECEASED (Type or print) MRS-Jessie First Middle Last D. Tidwell.		4. DATE OF DEATH March 12 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 5, 1897
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 1 Days 9 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Texas	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Hugh Calvin Douglas		14. MOTHER'S MAIDEN NAME Carrie B. Coleman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 465-18-9000	
17. INFORMANT Sister		Address 8604 Grant St. Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Meta static Carcinoma of breast. DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 20, 1960 to Mar. 12, 1960 , that (I) (we) last saw the deceased alive on Mar. 12 1960 , and that death occurred at 11:35 P.M. from the causes and on the date stated above.			
22a. SIGNATURE George A. Gray, Jr.		22b. DATE SIGNED 3/12/60	
22c. PHYSICIAN'S NAME (Type) George A. GRAY, JR., M.D.		22d. ADDRESS 4422 East West Highway, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar 15, 1960	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town, or county) (State) Montgomery County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Maryland	
25a. REC'D BY REGISTRAR MAR 16 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

OUTPOSTS

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TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 of 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3453

Item 2 Film 258 3-15-60 et

03598

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spencerville, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAIRLAND NURSING HOME</u>		d. STREET ADDRESS <u>FAIRLAND NURSING HOME</u>	
3. NAME OF DECEASED (Type or print) First <u>FLOYD W.</u> Middle <u>TILLEY</u> Last <u>TILLEY</u>		4. DATE OF DEATH Month <u>3</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 25 1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u>141.0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	
11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT TILLEY</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET PIGG</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>AUBREY TILLEY</u>	
17. INFORMANT <u>Son</u>		Address <u>Son</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of tongue with metastases</u> DUE TO (b) <u>141.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>metastases</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/25</u> <u>1960</u> , to <u>3/7</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>2/27</u> <u>1960</u> , and that death occurred on <u>3/7</u> <u>1960</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>C. H. HIGDON</u>		22b. DATE SIGNED <u>3/7/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. H. HIGDON</u>		22d. ADDRESS <u>Sandy Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/9/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Park Lawn</u>		23d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>		25a. REC'D BY REGISTRAR <u>MAR 10 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		25c. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

20784

MARY ANN LESTER
Lester Ann Lester
Lester Ann Lester

3432

21

104

[Faint, mostly illegible handwritten text, possibly a letter or journal entry, covering the majority of the page.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03599

3494
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>MONTGOMERY</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>17 TAKOMA PARK</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Curran Nursing Home 708 Philadelphia Avenue</i>		d. STREET ADDRESS <i>8401 BARRON ST</i>	
3. NAME OF DECEASED (Type or print) <i>MINNIE ALICE TOLSON</i>		4. DATE OF DEATH <i>March 11 1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JUNE 13, 1873</i>
9. AGE (In years last birthday) <i>86</i> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>	11. BIRTH PLACE (State or foreign country) <i>Washington, D.C.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Not Available</i>	
14. MOTHER'S MAIDEN NAME <i>Not Available</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Mrs. Lura McCarthy (same as #2)</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Severe Arteriosclerosis</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i> <i>10 years</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>3 May</i> , 1953, to <i>11 Mar.</i> , 1960, that I last saw the deceased alive on <i>9 March</i> , 1960, and that death occurred at <i>5:30 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>H.B. Queen</i>		ADDRESS (Street, city or town, state) <i>7112 Willow Ave</i> DATE SIGNED <i>11 Mar 1960</i>	
PHYSICIAN'S NAME (Type) <i>H. B. QUEEN</i>		ADDRESS <i>Takoma Park Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>March 14, 1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Frederick, Pr. Geo. Co., Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters</i> ADDRESS <i>254 Carroll St NW DC</i>		24a. REC'D BY REGISTRAR <i>DATE 14 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
16. SIGNATURE OF CLERK		17. SIGNATURE OF CHIEF CLERK		18. SIGNATURE OF ASSISTANT CLERK		19. SIGNATURE OF DEPUTY CLERK		20. SIGNATURE OF CLERK	
21. SIGNATURE OF CLERK		22. SIGNATURE OF CLERK		23. SIGNATURE OF CLERK		24. SIGNATURE OF CLERK		25. SIGNATURE OF CLERK	
26. SIGNATURE OF CLERK		27. SIGNATURE OF CLERK		28. SIGNATURE OF CLERK		29. SIGNATURE OF CLERK		30. SIGNATURE OF CLERK	
31. SIGNATURE OF CLERK		32. SIGNATURE OF CLERK		33. SIGNATURE OF CLERK		34. SIGNATURE OF CLERK		35. SIGNATURE OF CLERK	
36. SIGNATURE OF CLERK		37. SIGNATURE OF CLERK		38. SIGNATURE OF CLERK		39. SIGNATURE OF CLERK		40. SIGNATURE OF CLERK	
41. SIGNATURE OF CLERK		42. SIGNATURE OF CLERK		43. SIGNATURE OF CLERK		44. SIGNATURE OF CLERK		45. SIGNATURE OF CLERK	
46. SIGNATURE OF CLERK		47. SIGNATURE OF CLERK		48. SIGNATURE OF CLERK		49. SIGNATURE OF CLERK		50. SIGNATURE OF CLERK	
51. SIGNATURE OF CLERK		52. SIGNATURE OF CLERK		53. SIGNATURE OF CLERK		54. SIGNATURE OF CLERK		55. SIGNATURE OF CLERK	
56. SIGNATURE OF CLERK		57. SIGNATURE OF CLERK		58. SIGNATURE OF CLERK		59. SIGNATURE OF CLERK		60. SIGNATURE OF CLERK	
61. SIGNATURE OF CLERK		62. SIGNATURE OF CLERK		63. SIGNATURE OF CLERK		64. SIGNATURE OF CLERK		65. SIGNATURE OF CLERK	
66. SIGNATURE OF CLERK		67. SIGNATURE OF CLERK		68. SIGNATURE OF CLERK		69. SIGNATURE OF CLERK		70. SIGNATURE OF CLERK	
71. SIGNATURE OF CLERK		72. SIGNATURE OF CLERK		73. SIGNATURE OF CLERK		74. SIGNATURE OF CLERK		75. SIGNATURE OF CLERK	
76. SIGNATURE OF CLERK		77. SIGNATURE OF CLERK		78. SIGNATURE OF CLERK		79. SIGNATURE OF CLERK		80. SIGNATURE OF CLERK	
81. SIGNATURE OF CLERK		82. SIGNATURE OF CLERK		83. SIGNATURE OF CLERK		84. SIGNATURE OF CLERK		85. SIGNATURE OF CLERK	
86. SIGNATURE OF CLERK		87. SIGNATURE OF CLERK		88. SIGNATURE OF CLERK		89. SIGNATURE OF CLERK		90. SIGNATURE OF CLERK	
91. SIGNATURE OF CLERK		92. SIGNATURE OF CLERK		93. SIGNATURE OF CLERK		94. SIGNATURE OF CLERK		95. SIGNATURE OF CLERK	
96. SIGNATURE OF CLERK		97. SIGNATURE OF CLERK		98. SIGNATURE OF CLERK		99. SIGNATURE OF CLERK		100. SIGNATURE OF CLERK	

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3454
CERTIFICATE OF DEATH

03600

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			c. LENGTH OF STAY IN 1b 28 yrs.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7 HILLTOP ROAD			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First SIDNEY Middle A. Last TRUNDLE			4. DATE OF DEATH Month March Day 22 Year 19 60		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/21/82		9. AGE (In years last birthday) 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor Clerk		10b. KIND OF BUSINESS OR INDUSTRY C&P Telephone Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME HENRY CLAYTON TRUNDLE			14. MOTHER'S MAIDEN NAME EMMA SAPPINGTON		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 577-01-0922		17. INFORMANT Mrs. Katherine B. Trundle, 7 Hilltop Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thromboses, Multiple 332x DUE TO Cerebro-sclerosis, chronic Undetermined Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchiectasis with emphysema, chronic Chronic Coronary Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 1 month					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour— a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from July 1, 1956 to Mar 22, 1960 , that (I) (we) last saw the deceased alive on Mar 22, 1960 , and that death occurred at 9:15 P. M. from the causes and on the date stated above.					
22a. SIGNATURE George L. Ball		22b. DATE SIGNED Mar 22, 1960		22c. PHYSICIAN'S NAME (Type) George L. Ball	
22d. ADDRESS 16620 Georgia Ave Silver Spring, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/25/60		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY	
23d. LOCATION (City, town, or county)		(State) MONTGOMERY COUNTY, MARYLAND			
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. FUMHREY, INC. Raymond H. Ziska		ADDRESS SILVER SPRING, MD.		25a. RECEIVED BY REGISTRAR MAR 28 60 DATE	
25b. REGISTRAR'S SIGNATURE Charles S. Huns					

STATE OF TEXAS

1933

11

IN WITNESS WHEREOF

I have hereunto set my hand and seal

at the City of Austin

this 1st day of June

1933

1933

1

WITNESSED my hand and seal this 1st day of June

1933

3650

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 34 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 1723 34th Street N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Frederick Last TUCKER				4. DATE OF DEATH Month March Day 12 Year 1960			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-16-80	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) California	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Frederick A. TUCKER				14. MOTHER'S MAIDEN NAME Nora REARDON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW I & II 577 42 2577		INFORMANT (Wife) Mrs. Mildred S. Tucker Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) Bilateral Lower Lobe Pneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH many years many years							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7 February , 19 60 , to 12 March , 19 60 , that I last saw the deceased alive on 12 March , 19 60 , and that death occurred at 11:05 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE John W. Davis				ADDRESS (Street, city or town, state) DATE SIGNED M.D. U.S. Naval Hospital, Bethesda Md. 3-14-60			
PHYSICIAN'S NAME (Type) J.W. DAVIS LT MC USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-16-60		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Devot 2224 Wisconsin Ave. Bethesda Md.				24a. REC'D BY REGISTRAR DATE MAR 15 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

158

215

CERTIFICATE OF DEATH

3650

State of California

Washington

21 days

Deceased (Name)

1123 3rd Street N.W.

U.S. Naval Hospital, Bethesda, Md.

THURSDAY

John Frederick

4-18-50

Date

California

U.S. Government

U.S. Navy

John Frederick

Frederick A. Thomas

(Wife) Mrs. Mildred E. Thomas

WM 1-21 211 45 211

Age

1 February 1950

18 years

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

U.S. Naval Hospital, Bethesda, Md.

Virginia

Washington

1950

U.S. Naval Hospital, Bethesda, Md.

3495

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>day</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>5902 - 85 - Place</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Infant Girl</u> First <u>Infant</u> Middle <u>Girl</u> Last <u>Tyma</u>		4. DATE OF DEATH Month <u>3</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>Girl</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 2, 1960</u> 9. AGE (In years last birthday) yrs. <u>1</u> IF UNDER 1 YEAR Months <u>1</u> Days <u>12</u> IF UNDER 24 HRS. Min. <u>12</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>Takoma Park Md.</u> 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Stephen Tyma</u> 14. MOTHER'S MAIDEN NAME <u>Margaret Ann Watkins</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>Hospital Records</u> Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature</u> DUE TO <u>776x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>41 hr. 52 m</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 2, 1960</u> , to <u>March 4, 1960</u> , that I last saw the deceased alive on <u>March 4, 1960</u> , and that death occurred at <u>5:15 a.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10620 Georgia Ave., S.S., Md.</u> DATE SIGNED <u>April 21</u>			
ACTUAL SIGNATURE <u>Herbert J. Jacobs, M.D.</u>		PHYSICIAN'S NAME (Type) <u>Herbert J. Jacobs, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>March 7, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington San. & Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Takoma Park Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M.D. Wash. San. And Hospital</u>		24a. REC'D BY REGISTRAR <u>APR 26 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Carlton D. Hines</u>			

2075352xv0

VS AIS (4)
ISM-9/55

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3651

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03602

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 58 Chevy Chase d. STREET ADDRESS 8 East Lennox Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Henry Morehead Underwood		4. DATE OF DEATH Month March Day 1 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 17, 1893
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Colonel U.S. Army		10b. KIND OF BUSINESS OR INDUSTRY retired	
11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Underwood		14. MOTHER'S MAIDEN NAME Emma Younglove	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. yes	
17. INFORMANT Lt. Andrew F. Underwood (nephew)		Address Ft. Bragg, N.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		Address (Street, city, town, or county) 2 March 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 3/4/60	
22c. NAME OF CEMETERY OR CREMATORY LEE'S CREMATORY		22d. LOCATION (City, town, or country) (State) Washington, D.C.	
23. FUNERAL DIRECTOR LEE'S FUNERAL HOME 300 4th ST NE		24a. REC'D BY REGISTRAR MAR 7 '60 DATE 24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

1208

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3652

CERTIFICATE OF DEATH

03603

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 26 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Walter Victor Middle Rudolph Last VIEWEG				4. DATE OF DEATH Month March Day 20 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-19-02	
9. AGE (In years last birthday) 57 yrs.		10. UNDER 1 YEAR Months 5 Days 7 Hours 15 Min.		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy				10b. KIND OF BUSINESS OR INDUSTRY U.S. Government			
13. FATHER'S NAME Rudolf VIEWEG				14. MOTHER'S MAIDEN NAME Emma KLEIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 1924-1934			
17. INFORMANT (Wife) Anna R. Vieweg				Address Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Infarction, extensive 239X DUE TO anemia + Hypercalcemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal calcinosis & failure DUE TO (c) Parathyroid Tumor - functional							INTERVAL BETWEEN ONSET AND DEATH 24 hr. 3+ mo 6+ mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension & Congestive Heart failure, thrombophlebitis, Right leg + An.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto Crash			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that I attended the deceased from 23 February, 19 60 , to 20 March, 19 60 , that I last saw the deceased alive on 20 March, 19 60 , and that death occurred at 8:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Fred H. O'Connell				M.D. U.S. Naval Hospital, Bethesda, Md. 3-21-60			
PHYSICIAN'S NAME (Type) F.H. O'CONNELL LCDR MC USN				U.S. Naval Hospital, NNMC, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-23-60		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Gawler's				24a. REC'D BY REGISTRAR DATE MAR 24 '60		24b. REGISTRAR'S SIGNATURE Arthur S. ...	

3052

CERTIFICATE OF DEATH

NAME	WILLIAM J. BROWN
AGE	45
SEX	Male
RACE	White
DATE OF BIRTH	1910
PLACE OF BIRTH	U.S. Naval Hospital, Portsmouth, N.H.
DATE OF DEATH	1955
PLACE OF DEATH	U.S. Naval Hospital, Portsmouth, N.H.
CAUSE OF DEATH	Heart Disease
DATE OF BURIAL	1955
PLACE OF BURIAL	U.S. Naval Hospital, Portsmouth, N.H.

[Faint, illegible text, likely bleed-through from the reverse side of the page]

3653

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Rebecca Voigt</u>		4. DATE OF DEATH Month Day Year <u>Mar. 31 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 6, 1875</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>John Miller</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Burrows</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>myocardial infarct</u> (c) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Pyelonephritis, Uremic, Essential Hypertension</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 25, 1960</u> to <u>March 31, 1960</u> , that I last saw the deceased alive on <u>March 31, 1960</u> , and that death occurred at <u>5:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Henry Kelley</u> M.D.		ADDRESS (Street, city or town, state) <u>9902 Counselman Rd Bethesda 14 Md</u>	
PHYSICIAN'S NAME (Type) <u>Bethesda 14 Md</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/4/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chry Chan Funeral Home Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 4 '60</u>	
ADDRESS <u>5703 14th St. N.W. Wash. D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3853

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Place of death: _____

8. Cause of death: _____

9. Signature of physician: _____

10. Signature of registrar: _____

11. Date of registration: _____

3654 CERTIFICATE OF DEATH

Reg. Dist. No.

03605

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Arkansas b. COUNTY Arkansas		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Almyra		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			d. STREET ADDRESS PO Box 215		
3. NAME OF DECEASED (Type or print) First Karen Middle Faye Last Vos			4. DATE OF DEATH Month March Day 2 Year 1960		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 27, 1950		9. AGE (In years lost birthday) 10 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Arkansas
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Calvin Vos		
14. MOTHER'S MAIDEN NAME Eunice Roberts			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO. None			INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive gastro-intestinal hemorrhage 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Massive hemorrhage into lungs DUE TO (c) Acute leukemia					INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 weeks 21 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from February 8, 1960 to March 2, 1960 that I last saw the deceased alive on March 2, 1960 , and that death occurred at 11:40 PM , from the causes and on the date stated above.					
ACTUAL SIGNATURE Laurence A. Gaydos			ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3 Mar. 1960		
PHYSICIAN'S NAME (Type) Laurence A. Gaydos, M.D.			National Institutes of Health Bethesda 14, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		22b. DATE THEREOF 3/4/60		22c. NAME OF CEMETERY OR CREMATORY Almyra Cemetery	
22d. LOCATION (City, town, or county) Arkansas Co. Arkansas		22e. LOCATION (City, town, or county) Arkansas		22f. LOCATION (City, town, or county) Arkansas	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE MAR 7 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Pumphrey					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

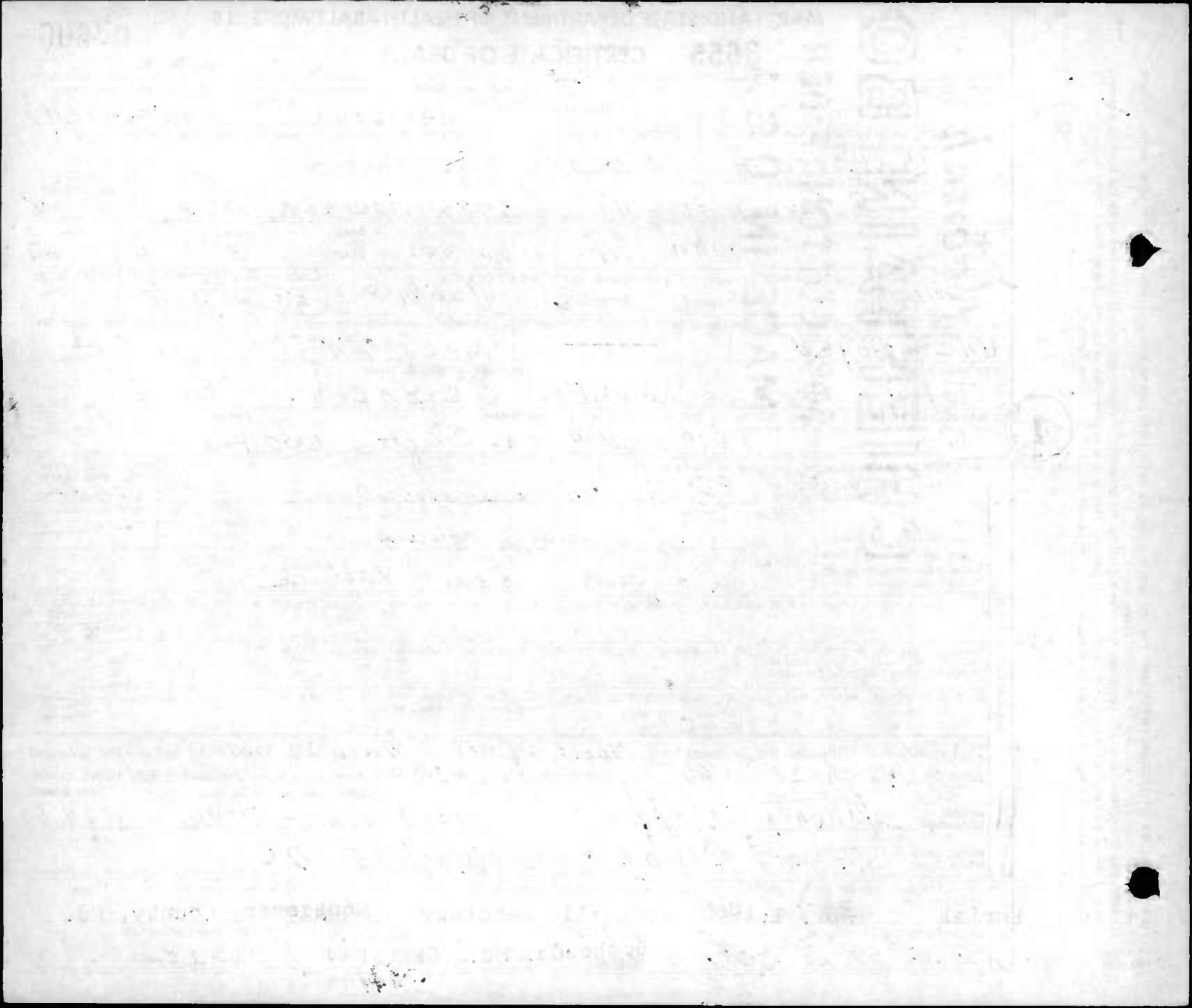
3655

CERTIFICATE OF DEATH

03606

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>A.</u> Last <u>Wagner</u>		4. DATE OF DEATH Month <u>3</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6/26/1900</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOHN ADAMS WAGNER</u>	
14. MOTHER'S MAIDEN NAME <u>ELIZABETH SHEER</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>212-05-6564</u>		INFORMANT <u>SON - Clifton Wagner</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1</u> DUE TO <u>Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Pulmonary edema</u> (c) <u>Constrictive heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 24, 1960</u> , to <u>March 29, 1960</u> , that I last saw the deceased alive on <u>March 27, 1960</u> , and that death occurred at <u>3:25 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stewart Clapp</u>		ADDRESS (Street, city or town, state) <u>3921 Ingomar St NW</u> DATE SIGNED <u>3-29-60</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>		<u>Wash 15 D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 1, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Humphrey</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAR 31 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

3656 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03607
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Dr. Bird Rd.</u>				d. STREET ADDRESS <u>1 Dr Bird Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Mildred Bathne Watson</u>				4. DATE OF DEATH <u>mar 20 1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2-26-1960</u>	9. AGE (In years last birthday) <u>24</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>4</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>							
13. FATHER'S NAME <u>Vernon Davis Watson</u>				14. MOTHER'S MAIDEN NAME <u>Deloris Hough</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Deloris Watson (mother)</u> Address <u>Thru 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>475X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>upper Resp. Infection</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>3-20-60</u>			
Address (Street, city, town, or county) <u>—</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/23/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Pleasant</u>		22d. LOCATION (City, town, or country) (State) <u>Norbeck, Md.</u>	
23. FUNERAL DIRECTOR <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md</u>				24a. REC'D BY REGISTRAR <u>MAR 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

VS. A15ME
5M 7/59
How 4/6/60

2073367XV3

1000

3886 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR THE
STATE OF

1

1

1

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Usual residence: _____

7. Cause of death: _____

8. Manner of death: _____

9. Signature of medical examiner: _____

10. Date: _____

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3516

Item 2 Film G258 3-15-60 et

CERTIFICATE OF DEATH

03608

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Tipton Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville Chevy Chase	
		d. STREET ADDRESS 1216 Baltimore Road	
3. NAME OF DECEASED (Type or print) First ANNIE Middle LOUISA Last WHEELER		4. DATE OF DEATH Month March Day 8 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 5, 1886
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 7 Days 3 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operator		10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.	
11. BIRTHPLACE (State or foreign country) ARLINGTON MASS.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LOUIS GREATY		14. MOTHER'S MAIDEN NAME Helen MAUDE SNOW NEWFOUNDLAND	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-20-1132A	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension DUE TO (c) Atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 day 15-20 yrs	
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While at work	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1230A		20d. (City or town) (County) (State) Rockland, Massachusetts	
21. I certify that I attended the deceased from 1948 to 8 MAR 1960 that I last saw the deceased alive on 9 Jul 1960 , and that death occurred at 12:30A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 906 Walsville Rd Silver Spring Maryland DATE SIGNED 3/15/60			
ACTUAL SIGNATURE William D. Aud M.D.		PHYSICIAN'S NAME (Type) William D. Aud	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit 3/11/60		22b. DATE THEREOF 3/11/60	
22c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cemetery		22d. LOCATION (City, town, or county) (State) Rockland, Massachusetts	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Fumphyrey		24a. REC'D BY REGISTRAR Bethesda, Maryland DATE MAR 10 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, Form G260 4/11/60 1b

3496

CERTIFICATE OF DEATH

03609

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ADELPHI</u>	
c. LENGTH OF STAY IN 1b <u>33 HRS</u>		d. STREET ADDRESS <u>1002 Heather, Takoma Park, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM & HOSP</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NORA</u> Middle <u>M</u> Last <u>WHEELER</u>		4. DATE OF DEATH Month <u>3</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 15 85</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(UNKNOWN) LEVIGNE</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT Address <u>HOSPITAL RECORDS</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction due to embolus</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>from mural thrombus left auricular appendage</u> DUE TO <u>arteriosclerotic heart disease</u> (c) <u>pyelonephritis + Hydronephrosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 1953, to <u>March 30</u> , 1960, that I last saw the deceased alive on <u>March 30</u> , 1960, and that death occurred at <u>4:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Boris Rabkin</u> M.D. <u>1019 University Blvd, East 3/30/60</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>BORIS RABKIN</u> <u>Silver Spring, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/2/1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co. Inc 517 11th St. SE</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>APR 4 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH HOME		SEX FEMALE	
DATE OF DEATH JAN 10 1954		AGE 78	
PLACE OF BIRTH BALTIMORE, MD		RACE WHITE	
OCCUPATION HOUSEWIFE		MARITAL STATUS MARRIED	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
TIME OF DEATH 11:00 AM		PLACE OF INTERMENT GREENWOOD CEMETERY	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)	

This certificate is to be filled out by the physician or coroner who has examined the body and determined the cause of death. It is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland.

3497 CERTIFICATE OF DEATH

Reg. Dist. No.

03610

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakoma Park</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>075 Washington Sav & Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JANE</u> First <u>MMN</u> Middle <u>Williams</u> Last				4. DATE OF DEATH Month <u>3</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-16-89</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>							
13. FATHER'S NAME <u>James Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Mary Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Pt Chard</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO <u>Arteriosclerosis - Coronary Arteries</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>Undetermined</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u> </u>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb 18, 1960</u> to <u>Mar 18, 1960</u> , that I last saw the deceased alive on <u>Mar 18, 1960</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>George L Ball</u> M.D. <u>10520 Silver Spring Rd</u> <u>Mar 18, 1960</u>							
PHYSICIAN'S NAME (Type) <u>George L Ball</u> <u>Silver Spring Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>							
22b. DATE THEREOF <u>3/22/60</u>							
22c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn</u>							
22d. LOCATION (City, town, or county) (State) <u>Del Co, Md</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>LIFE FUNERAL HOME</u> ADDRESS <u>300 4th St NE</u>							
24a. REC'D BY REGISTRAR DATE <u>MAR 22 '60</u>							
24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 12 Film G261 4-14-60 et Item 14 Film G259 3-31-60 et Item 3, 7, 11, 13, 16, 17 & 22, Film G-280 4/11/60.cac

CERTIFICATE OF DEATH

Reg. Dist. No.

03611

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Essex	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Orange	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14511 Colesville Road		d. STREET ADDRESS 64 Whittingham Place	
3. NAME OF DECEASED (Type or print) MAE		4. DATE OF DEATH Month March Day 22 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7/10/1877
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 8 Days 12 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Iowa/ Ireland		12. CITIZEN OF WHAT COUNTRY? US U.S.A.	
13. FATHER'S NAME Halliday William Holladay		14. MOTHER'S MAIDEN NAME Unknown Mary Laurence	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Williams-son-5822 Greenlawn Rd Drive		Address Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) years		INTERVAL BETWEEN ONSET AND DEATH 10 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-13 , 19 59 , to 3-22 , 19 60 , that I last saw the deceased alive on 3-21 , 19 60 , and that death occurred at 3:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John S. Rogers		DATE SIGNED 3-22-60	
PHYSICIAN'S NAME (Type) John S. Rogers		ADDRESS (Street, city or town, state) 1919 Seminary Rd. Silver Spring Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/25/60	
22c. NAME OF CEMETERY OR CREMATORY Rosedale Cemetery		22d. LOCATION (City, town, or county) (State) Orange, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR MAR 28 '60	
ADDRESS Bethesda, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

SEX

RACE

EDUCATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

SEX

RACE

EDUCATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

SEX

RACE

3657

CERTIFICATE OF DEATH

03612

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, MD</u>		c. LENGTH OF STAY IN 1b <u>5</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY MARGARET WILLIAMS</u>		4. DATE OF DEATH Month Day Year <u>MARCH 16 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/23/18</u>
9. AGE (In years last birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Nathan Frazier</u>	
14. MOTHER'S MAIDEN NAME <u>Stel Nandy</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>INFORMANT</u>		17. ADDRESS <u>Mrs Walter McRoy 284 2112 Ave Rockville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary infarction</u> <u>465X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary embolism</u> DUE TO (c) <u>Diabetes Mellitus - Bronchopneumonia double lung</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus - Bronchopneumonia double lung</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20c. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>3.11.1960</u> to <u>3.16.1960</u> , that I last saw the deceased alive on <u>3.15.1960</u> , and that death occurred at <u>1:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stewart Clapp</u>		ADDRESS (Street, city or town, state) <u>3921 Ingomar St Wash 15 D.C.</u>	
DATE SIGNED <u>3.16.60</u>		PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/17/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Shawlen</u>		ADDRESS <u>Rockville, Md</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Knap</u>	

1

hours after death. Page 4

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

3657

1912

NAME

RESIDENCE

DATE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Minister

Signature of Justice

Signature of Notary

Signature of Clerk

Signature of Treasurer

Signature of Auditor

Signature of Controller

Signature of Comptroller

Signature of Secretary

Signature of Assistant Secretary

Signature of Chief Clerk

Signature of Deputy Chief Clerk

Signature of Chief of Bureau

Signature of Assistant Chief of Bureau

Signature of Chief of Division

Signature of Assistant Chief of Division

Signature of Chief of Section

Signature of Assistant Chief of Section

Signature of Chief of Office

Signature of Assistant Chief of Office

Signature of Chief of Unit

Signature of Assistant Chief of Unit

Signature of Chief of Detail

Signature of Assistant Chief of Detail

Signature of Chief of Staff

Signature of Assistant Chief of Staff

Signature of Chief of Administration

Signature of Assistant Chief of Administration

3658 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 5 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 4401 Oak Hill Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) Diane Sada Witt		4. DATE OF DEATH Month March Day 6 Year 1960		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 18, 1957		9. AGE (In years last birthday) 2 yrs.		10. IF UNDER 1 YEAR Months 2		11. IF UNDER 24 HRS. Days 2		12. IF UNDER 24 HRS. Hours 2		13. IF UNDER 24 HRS. Min. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (State or foreign country) District of Columbia				12. CITIZEN OF WHAT COUNTRY? U. S. A.									
13. FATHER'S NAME Franklyn R. Witt				14. MOTHER'S MAIDEN NAME Thelma Stansbury				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None				17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Gastro-Intestinal Hemorrhage 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. (City or town) (County) (State)																					
21. I certify that I attended the deceased from March 1 , 19 60 , to March 6 , 19 60 , that I last saw the deceased alive on March 6 , 19 60 , and that death occurred at 1:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 3-6-60 ACTUAL SIGNATURE Richard C. Mechanic M.D. PHYSICIAN'S NAME (Type) RICHARD C. MECHANIC, M.D. National Institutes of Health Bethesda 14, Maryland																					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 3/9/60				22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY				22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND									
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. BUMPHREY, INC. Raymond A. Ziska				ADDRESS SILVER SPRING, MD.				24a. REC'D BY REGISTRAR DATE MAR 9 '60				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3659

CERTIFICATE OF DEATH

Item 4 PL 11-11-57 3-23-60 et

03614

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 57 Bethesda		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8102 Maple Ridge Road			d. STREET ADDRESS 8102 Maple Ridge Road		
3. NAME OF DECEASED (Type or print) First Middle Last ANDREW W WOLTER			4. DATE OF DEATH Month Day Year March 8 7, 19 60		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/14/1904		9. AGE (In years lost birthday) 55 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice President		10b. KIND OF BUSINESS OR INDUSTRY United Brick Co		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME Andrew H. Wolter			
14. MOTHER'S MAIDEN NAME Mary Thompson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Frances Wolter-wife-same as 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 430.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Not Known					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 1		(County) 1		(State) 1	
21. I certify that (I) (this hospital) attended the deceased from Nov. 1948 to March 2, 1960 , that (I) (we) last saw the deceased alive on March 2, 1960 , and that death occurred at 5:15 P.M. from the causes and on the date stated above.					
22a. SIGNATURE W. T. Joyce		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) W. T. Joyce	
22d. ADDRESS 8102 Maple Ridge Rd, Bethesda, Md		22e. ADDRESS 8102 Maple Ridge Rd, Bethesda, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/10/60		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.	
23d. LOCATION (City, town, or county) Silver Spring, Maryland		(State) 1			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR MAR 10 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume		25c. REGISTRAR'S SIGNATURE Arthur S. Hume			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT

MEDICAL CERTIFICATION

MONTGOMERY STATE DEPARTMENT OF HEALTH											
Division 3660 STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
03615											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rt 2</u>						d. STREET ADDRESS <u>Rt 2</u>					
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>George Austin Young</u>						4. DATE OF DEATH <u>Mar 9 1960</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-6-1889</u>		9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mail carrier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Sampson Young</u>						14. MOTHER'S MAIDEN NAME <u>Lucille Baker</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)						16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Geo A. Young Jr.</u>		Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) } (a), stating the underlying cause last. (c) } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>3-9-60</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)					
<u>Burial</u>		<u>3/14/60</u>		<u>Mount Olivet Cemetery</u>		<u>Frederick, Maryland</u>					
23. FUNERAL DIRECTOR <u>M. R. Etchison & Son; Frederick, Maryland</u>						24a. REC'D BY REGISTRAR <u>MAR 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
0616

NEW YORK
JAN 1 1900

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DECEASED
NAME
AGE
SEX
RACE
BORN
DIED
PLACE
CITY
COUNTY
STATE
OCCUPATION
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE
DATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

3498

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03616

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>15 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Nicholas Ruras</u>		4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Greek</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-1-67</u>
9. AGE (In years last birthday) <u>93</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Produce Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Nicholas Luras</u>		14. MOTHER'S MAIDEN NAME <u>Marie MANTZOURAS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Marie Z. Harris</u>		Address <u>10435 Edgewood Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Disease</u> DUE TO <u>Age</u> (b) <u>Carcinoma of Prostate</u> DUE TO <u>5 yrs</u> (c) <u>177X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> 19 to <u>3/11</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>3/11</u> 19 <u>60</u> , and that death occurred at <u>1:30</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Oliver E. Thompson</u>		22b. DATE SIGNED <u>3/11/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>OLIVER E. THOMPSON</u>		22d. ADDRESS <u>901 Pershing Drive, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/14/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pimphrey, Inc.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR <u>MAR 15 60</u>	
DATE		DATE	

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